

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: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/25/2014 4:15 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/25/2014 Time: 4:15 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT CARMEL HOSPITAL (150157) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	64,632	62,631	-63,413	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	64,632	62,631	-63,413	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/25/2014 3:49 pm
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
1.00	Street: 13500 NORTH MERIDIAN STREET	PO Box:		1.00
2.00	City: CARMEL	State: IN	Zip Code: 46033	2.00
			County: HAMILTON	

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

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ST. VINCENT CARMEL HOSPITAL	150157	26900	1	01/14/2004	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2013	06/30/2014	20.00
21.00	Type of Control (see instructions)	1		21.00

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	Y			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
24.00	759	598	0	0	1,129	0	24.00
25.00	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)	N	N			39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	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		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20
				1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))
			1.00	2.00	3.00
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>					
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	64.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))
			1.00	2.00	3.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	65.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))
			1.00	2.00	3.00
<u>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</u>					
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	66.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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			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	N	N
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		
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.		1		
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	118,316	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		
119.00	DO NOT USE THIS LINE				
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
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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.				
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	269008	

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1.00		2.00		3.00										
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.														
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08101		141.00								
142.00	Street: 10330 N. MERIDIAN STREET	PO Box:				142.00								
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46290		143.00								
						1.00								
144.00	Are provider based physicians' costs included in Worksheet A?						Y 144.00							
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.						N 145.00							
						1.00								
						2.00								
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N 146.00							
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N 147.00							
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N 148.00							
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N 149.00							
		Part A		Part B		Title V		Title XIX						
		1.00		2.00		3.00		4.00						
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)														
155.00	Hospital	N		N		N		N 155.00						
156.00	Subprovider - IPF	N		N		N		N 156.00						
157.00	Subprovider - IRF	N		N		N		N 157.00						
158.00	SUBPROVIDER							158.00						
159.00	SNF	N		N		N		N 159.00						
160.00	HOME HEALTH AGENCY	N		N		N		N 160.00						
161.00	CMHC			N		N		N 161.00						
						1.00								
Multi campus														
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N		165.00					
		Name		County		State		Zip Code		CBSA		FTE/Campus		
		0		1.00		2.00		3.00		4.00		5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5										0.00		166.00	
						1.00								
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act														
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y		167.00					
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0 168.00					
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.75		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)						10/01/2013		09/30/2014		170.00			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 11/25/2014 3:49 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/21/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	10/21/2014		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150157

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

Worksheet S-3
Part I
Date/Time Prepared:
11/25/2014 3:49 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Trips	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	128	46,720	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		128	46,720	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,650	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 SPECIAL CARE NURSERY	35.00	15	5,475	0.00	0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		153	55,845	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		153				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150157

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

Worksheet S-3
Part I
Date/Time Prepared:
11/25/2014 3:49 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	3,803	458	12,043			1.00
2.00 HMO and other (see instructions)	890	1,727				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,803	458	12,043			7.00
8.00 INTENSIVE CARE UNIT	364	59	1,038			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 SPECIAL CARE NURSERY	0	185	1,904			12.00
13.00 NURSERY		50	3,237			13.00
14.00 Total (see instructions)	4,167	752	18,222	0.00	590.36	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	590.36	27.00
28.00 Observation Bed Days		0	2,100			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			904			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	7	821			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150157

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

Worksheet S-3
Part I
Date/Time Prepared:
11/25/2014 3:49 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,094	307	6,137	1.00
2.00 HMO and other (see instructions)			243	0		2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 SPECIAL CARE NURSERY						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,094	307	6,137	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150157

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

Worksheet S-3
Part II
Date/Time Prepared:
11/25/2014 3:49 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	43,782,719	0	43,782,719	1,227,952.00	35.66
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		2,952,809	0	2,952,809	21,963.00	134.44
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		5,747,443	0	5,747,443	156,816.00	36.65
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		165,929	0	165,929	2,982.00	55.64
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office salaries & wage-related costs		7,354,244	0	7,354,244	167,304.00	43.96
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,428,728	0	8,428,728		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,389,157	0	1,389,157		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		764,393	0	764,393		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	698,826	0	698,826	12,289.00	56.87
27.00	Administrative & General	5.00	5,578,363	0	5,578,363	174,606.00	31.95
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	819,579	0	819,579	32,213.00	25.44
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00
33.00	Housekeeping under contract (see instructions)		1,542,543	0	1,542,543	66,062.00	23.35
34.00	Dietary	10.00	0	0	0	0.00	0.00
35.00	Dietary under contract (see instructions)		604,175	0	604,175	25,742.00	23.47
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,502,216	0	1,502,216	35,680.00	42.10
39.00	Central Services and Supply	14.00	283,623	0	283,623	16,669.00	17.01
40.00	Pharmacy	15.00	1,997,419	0	1,997,419	50,124.00	39.85

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150157

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

Worksheet S-3
Part II
Date/Time Prepared:
11/25/2014 3:49 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adj uste d Sal ari es (col . 2 ± col . 3)	Pai d Hou rs Rel ated to Sal ari es i n col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medi cal Records & Medi cal Records Li brary	16.00 335,028	0	335,028	13,008.00	25.76	41.00
42.00	Soci al Servi ce	17.00 130,516	0	130,516	4,762.00	27.41	42.00
43.00	Other General Servi ce	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150157

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

Worksheet S-3
Part III
Date/Time Prepared:
11/25/2014 3:49 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	42,976,628	0	42,976,628	1,297,793.00	33.12	1.00
2.00	Excluded area salaries (see instructions)	5,747,443	0	5,747,443	156,816.00	36.65	2.00
3.00	Subtotal salaries (line 1 minus line 2)	37,229,185	0	37,229,185	1,140,977.00	32.63	3.00
4.00	Subtotal other wages & related costs (see inst.)	7,520,173	0	7,520,173	170,286.00	44.16	4.00
5.00	Subtotal wage-related costs (see inst.)	8,428,728	0	8,428,728	0.00	22.64	5.00
6.00	Total (sum of lines 3 thru 5)	53,178,086	0	53,178,086	1,311,263.00	40.55	6.00
7.00	Total overhead cost (see instructions)	13,492,288	0	13,492,288	431,155.00	31.29	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet S-3 Part IV Date/Time Prepared: 11/25/2014 3:49 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		862,306	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		5,242,665	8.00
9.00	Prescription Drug Plan		1,024,434	9.00
10.00	Dental, Hearing and Vision Plan		85,391	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		37,393	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		2,971	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		175,114	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		136,340	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		2,855,719	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		118,123	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		22,193	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		19,629	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		10,582,278	24.00
Part B - Other than Core Related Cost				
25.00	OTHER		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet S-3 Part V Date/Time Prepared: 11/25/2014 3:49 pm
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	165,929	10,582,278	1.00
2.00	Hospital	165,929	8,428,728	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	2,153,550	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 150157

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

Worksheet S-10

Date/Time Prepared:
11/25/2014 3:49 pm

				1.00		
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.247571	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			2,720,110	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			28,075,983	6.00	
7.00	Medicaid cost (line 1 times line 6)			6,950,799	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)			4,230,689	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone SCHIP			0	9.00	
10.00	Stand-alone SCHIP charges			0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			20,120	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			4,230,689	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility			6,885,175	146,972	7,032,147
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)			1,704,570	36,386	1,740,956
22.00	Partial payment by patients approved for charity care			0	0	0
23.00	Cost of charity care (line 21 minus line 22)			1,704,570	36,386	1,740,956
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit					0
26.00	Total bad debt expense for the entire hospital complex (see instructions)			5,678,171		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			82,702		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			5,595,469		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			1,385,276		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,126,232		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			7,356,921		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150157

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

Worksheet A
Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		5,926,251	5,926,251	0	5,926,251	1.00
2.00	00200		2,631,734	2,631,734	0	2,631,734	2.00
4.00	00400	698,826	11,183,815	11,882,641	0	11,882,641	4.00
5.01	00540	0	620,737	620,737	0	620,737	5.01
5.02	00550	158,890	7,916	166,806	0	166,806	5.02
5.03	00561	579,385	398,637	978,022	0	978,022	5.03
5.04	00570	1,571,789	849,372	2,421,161	-2,043,040	378,121	5.04
5.05	00580	0	0	0	1,301,219	1,301,219	5.05
5.06	00571	0	0	0	741,821	741,821	5.06
5.07	00590	3,268,299	5,943,961	9,212,260	0	9,212,260	5.07
7.00	00700	819,579	2,378,562	3,198,141	0	3,198,141	7.00
8.00	00800	0	485,031	485,031	0	485,031	8.00
9.00	00900	0	1,786,873	1,786,873	0	1,786,873	9.00
10.00	01000	0	2,079,285	2,079,285	-1,242,788	836,497	10.00
11.00	01100	0	0	0	1,242,788	1,242,788	11.00
13.00	01300	1,502,216	127,087	1,629,303	0	1,629,303	13.00
14.00	01400	283,623	35,067	318,690	0	318,690	14.00
15.00	01500	1,997,419	2,800,716	4,798,135	0	4,798,135	15.00
16.00	01600	335,028	369,932	704,960	0	704,960	16.00
17.00	01700	130,516	56,135	186,651	0	186,651	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,340,435	1,620,758	10,961,193	-1,094,121	9,867,072	30.00
31.00	03100	1,013,089	654,869	1,667,958	0	1,667,958	31.00
35.00	02040	2,358,199	151,784	2,509,983	-13,278	2,496,705	35.00
43.00	04300	0	0	0	1,137,081	1,137,081	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,811,649	8,809,793	12,621,442	0	12,621,442	50.00
52.00	05200	1,609,300	1,715,296	3,324,596	3,360	3,327,956	52.00
54.00	05400	2,009,842	2,160,750	4,170,592	-58,094	4,112,498	54.00
54.02	05402	63,191	204	63,395	58,094	121,489	54.02
57.00	05700	156,957	49,650	206,607	0	206,607	57.00
58.00	05800	354,924	303,926	658,850	0	658,850	58.00
60.00	06000	60,476	2,557,160	2,617,636	0	2,617,636	60.00
65.00	06500	1,119,590	184,280	1,303,870	0	1,303,870	65.00
66.00	06600	219,033	4,571	223,604	0	223,604	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	13,502	0	13,502	0	13,502	68.00
69.00	06900	34,896	189,804	224,700	0	224,700	69.00
70.00	07000	79,090	19,638	98,728	0	98,728	70.00
71.00	07100	0	1,803,942	1,803,942	0	1,803,942	71.00
72.00	07200	0	2,736,941	2,736,941	0	2,736,941	72.00
73.00	07300	0	0	0	0	0	73.00
75.00	07500	1,732,908	11,750,060	13,482,968	0	13,482,968	75.00
76.00	03020	1,032,377	2,318,839	3,351,216	-29,803	3,321,413	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	1,680,248	502,681	2,182,929	-3,239	2,179,690	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		38,035,276	75,216,057	113,251,333	0	113,251,333	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	73,412	326,620	400,032	0	400,032	190.00
192.00	19200	310,735	5,931	316,666	0	316,666	192.00
194.00	07950	0	577	577	0	577	194.00
194.01	07951	0	1,951	1,951	0	1,951	194.01
194.02	07952	0	135	135	0	135	194.02
194.04	07954	0	0	0	0	0	194.04
194.06	07956	5,363,296	1,322,842	6,686,138	0	6,686,138	194.06
200.00		43,782,719	76,874,113	120,656,832	0	120,656,832	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150157

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

Worksheet A
Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,071,172	4,855,079	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,631,734	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,090,523	13,973,164	4.00
5.01	00540	NONPATIENT TELEPHONES	300,244	920,981	5.01
5.02	00550	DATA PROCESSING	3,859,014	4,025,820	5.02
5.03	00561	PURCHASING RECEIVING AND STORES	474,196	1,452,218	5.03
5.04	00570	IP ADMINITTING	180,174	558,295	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,466,991	2,768,210	5.05
5.06	00571	OP REGISTRATION	72,853	814,674	5.06
5.07	00590	OTHER ADMINISTRATIVE AND GENERAL	-7,870,616	1,341,644	5.07
7.00	00700	OPERATION OF PLANT	-64,952	3,133,189	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	485,031	8.00
9.00	00900	HOUSEKEEPING	0	1,786,873	9.00
10.00	01000	DIETARY	-9,390	827,107	10.00
11.00	01100	CAFETERIA	-535,295	707,493	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,629,303	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-57	318,633	14.00
15.00	01500	PHARMACY	-306,228	4,491,907	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	442,187	1,147,147	16.00
17.00	01700	SOCIAL SERVICE	0	186,651	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,301,505	7,565,567	30.00
31.00	03100	INTENSIVE CARE UNIT	-44	1,667,914	31.00
35.00	02040	SPECIAL CARE NURSERY	-1,271,441	1,225,264	35.00
43.00	04300	NURSERY	0	1,137,081	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-981,562	11,639,880	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,257,135	2,070,821	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-213,765	3,898,733	54.00
54.02	05402	ULTRASOUND	0	121,489	54.02
57.00	05700	CT SCAN	-4,250	202,357	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-24	658,826	58.00
60.00	06000	LABORATORY	0	2,617,636	60.00
65.00	06500	RESPIRATORY THERAPY	-83	1,303,787	65.00
66.00	06600	PHYSICAL THERAPY	-3	223,601	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,502	68.00
69.00	06900	ELECTROCARDIOLOGY	0	224,700	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-68	98,660	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,803,942	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,736,941	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	13,482,968	75.00
76.00	03020	ENDOSCOPY	-43	3,321,370	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-40,133	2,139,557	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,041,584	106,209,749	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	400,032	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	316,666	192.00
194.00	07950	MISSION EFFECTIVENESS	0	577	194.00
194.01	07951	MARKETING	1,276,773	1,278,724	194.01
194.02	07952	JOINT VENTURES	0	135	194.02
194.04	07954	VACANT	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	-22	6,686,116	194.06
200.00		TOTAL (SUM OF LINES 118-199)	-5,764,833	114,891,999	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - PATIENT FINANCIAL SERVICES					
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	669,144	632,075	1.00
	TOTALS		669,144	632,075	
B - BUSINESS OFFICE					
1.00	OP REGISTRATION	5.06	571,258	170,563	1.00
	TOTALS		571,258	170,563	
C - ENDOSCOPY					
1.00	ADULTS & PEDIATRICS	30.00	33,042	0	1.00
2.00		0.00	0	0	2.00
	TOTALS		33,042	0	
D - NURSERY					
1.00	NURSERY	43.00	967,414	149,630	1.00
	TOTALS		967,414	149,630	
E - INTEREST EXPENSE					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.07	0	67,247	1.00
	TOTALS		0	67,247	
F - NURSERY DIRECTOR					
1.00	NURSERY	43.00	20,037	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	3,360	0	2.00
	TOTALS		23,397	0	
G - CAFETERIA					
1.00	CAFETERIA	11.00	0	1,242,788	1.00
	TOTALS		0	1,242,788	
H - ULTRASOUND					
1.00	ULTRASOUND	54.02	0	58,094	1.00
	TOTALS		0	58,094	
500.00	Grand Total: Increases		2,264,255	2,320,397	500.00

RECLASSIFICATIONS

Provider CCN: 150157

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

Worksheet A-6
Date/Time Prepared:
11/25/2014 3:49 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - PATIENT FINANCIAL SERVICES							
1.00	IP_ADMI TTING	5.04	669,144	632,075	0		1.00
	TOTALS		669,144	632,075			
B - BUSINESS OFFICE							
1.00	IP_ADMI TTING	5.04	571,258	170,563	0		1.00
	TOTALS		571,258	170,563			
C - ENDOSCOPY							
1.00	ENDOSCOPY	76.00	29,803	0	0		1.00
2.00	EMERGENCY	91.00	3,239	0	0		2.00
	TOTALS		33,042	0			
D - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	967,414	149,630	0		1.00
	TOTALS		967,414	149,630			
E - INTEREST EXPENSE							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.07	0	67,247	0		1.00
	TOTALS		0	67,247			
F - NURSERY DIRECTOR							
1.00	ADULTS & PEDIATRICS	30.00	10,119	0	0		1.00
2.00	SPECIAL CARE NURSERY	35.00	13,278	0	0		2.00
	TOTALS		23,397	0			
G - CAFETERIA							
1.00	DIETARY	10.00	0	1,242,788	0		1.00
	TOTALS		0	1,242,788			
H - ULTRASOUND							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	58,094	0		1.00
	TOTALS		0	58,094			
500.00	Grand Total: Decreases		2,264,255	2,320,397			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150157

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

Worksheet A-7
Part I
Date/Time Prepared:
11/25/2014 3:49 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,111,746	0	0	0	1.00
2.00	Land Improvements	2,224,113	0	0	0	2.00
3.00	Buildings and Fixtures	35,500,660	0	0	0	3.00
4.00	Building Improvements	32,622,503	1,722,212	0	1,722,212	4.00
5.00	Fixed Equipment	3,157,901	0	0	0	5.00
6.00	Movable Equipment	30,613,363	861,265	0	861,265	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	106,230,286	2,583,477	0	2,583,477	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	106,230,286	2,583,477	0	2,583,477	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,111,746	0			1.00
2.00	Land Improvements	2,224,113	1,599,024			2.00
3.00	Buildings and Fixtures	35,500,660	4,910,202			3.00
4.00	Building Improvements	34,099,609	12,245,175			4.00
5.00	Fixed Equipment	2,791,447	933,601			5.00
6.00	Movable Equipment	31,244,238	20,481,206			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	107,971,813	40,169,208			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	107,971,813	40,169,208			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150157

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

Worksheet A-7
Part II
Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	2,374,989	3,435,088	0	57,207	58,545	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,090,615	538,085	0	3,034	0	2.00
3.00	Total (sum of lines 1-2)	4,465,604	3,973,173	0	60,241	58,545	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	422	5,926,251				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,631,734				2.00
3.00	Total (sum of lines 1-2)	422	8,557,985				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150157

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

Worksheet A-7
Part III
Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	73,936,128	0	73,936,128	0.684772	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	34,035,685	0	34,035,685	0.315228	0	2.00
3.00	Total (sum of lines 1-2)	107,971,813	0	107,971,813	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,765,226	2,974,101	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,090,615	538,085	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,855,841	3,512,186	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col.s. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	57,207	58,545	0	4,855,079	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,034	0	0	2,631,734	2.00
3.00	Total (sum of lines 1-2)	0	60,241	58,545	0	7,486,813	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150157

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

Worksheet A-8

Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-369,047	CAP REL COSTS-BLDG & FIXT		1.00	9	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			CAP REL COSTS-MVBLE EQUIP		2.00		2.00
3.00 Investment income - other (chapter 2)	A	-40,700	OTHER ADMINISTRATIVE AND GENERAL		5.07		3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00		4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00		5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00		6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00		7.00
8.00 Television and radio service (chapter 21)		0			0.00		8.00
9.00 Parking lot (chapter 21)		0			0.00		9.00
10.00 Provider-based physician adjustment	A-8-2	-5,824,908					10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00		11.00
12.00 Related organization transactions (chapter 10)	A-8-1	7,043,520					12.00
13.00 Laundry and linen service		0			0.00		13.00
14.00 Cafeteria-employees and guests	B	-535,295	CAFETERIA		11.00		14.00
15.00 Rental of quarters to employee and others		0			0.00		15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00		16.00
17.00 Sale of drugs to other than patients	B	-306,189	PHARMACY		15.00		17.00
18.00 Sale of medical records and abstracts		0			0.00		18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00		19.00
20.00 Vending machines		0			0.00		20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00		21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00		22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY		65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY		66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***		114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			CAP REL COSTS-BLDG & FIXT		1.00		26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			CAP REL COSTS-MVBLE EQUIP		2.00		27.00
28.00 Non-physician Anesthetist			*** Cost Center Deleted ***		19.00		28.00
29.00 Physicians' assistant					0.00		29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY		67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS		30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY		68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest					0.00		32.00
33.00 ENTERTAINMENT EXPENSE	A	-21	OPERATING ROOM		50.00		33.00
34.00 OTHER MISC REVENUE	B	-5,041	EMPLOYEE BENEFITS DEPARTMENT		4.00		34.00

Provider CCN: 150157

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

Worksheet A-8

Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
35.00 OTHER MI SC REVENUE	B	-462	IP ADMITTING	5.04	0 35.00
36.00 OTHER MI SC REVENUE	B	-20,065	OTHER ADMINISTRATIVE AND GENERAL	5.07	0 36.00
37.00 OTHER MI SC REVENUE	B	-64,952	OPERATION OF PLANT	7.00	0 37.00
38.00 OTHER MI SC REVENUE	B	-9,390	DIETARY	10.00	0 38.00
39.00 OTHER MI SC REVENUE	B	-405,594	ADULTS & PEDIATRICS	30.00	0 39.00
40.00 OTHER MI SC REVENUE	B	-1	SPECIAL CARE NURSERY	35.00	0 40.00
41.00 OTHER MI SC REVENUE	B	-100	OPERATING ROOM	50.00	0 41.00
42.00 OTHER MI SC REVENUE	B	-650	RADIOLOGY-DIAGNOSTIC	54.00	0 42.00
43.00 PROPERTY RENTAL INCOME	B	-460,987	CAP REL COSTS-BLDG & FIXT	1.00	10 43.00
44.00 PROVIDER ASSESSMENT OFFSET	A	-4,762,807	OTHER ADMINISTRATIVE AND GENERAL	5.07	0 44.00
45.00 LOBBYING	A	-1,722	OTHER ADMINISTRATIVE AND GENERAL	5.07	0 45.00
46.00 LOSS ON SALE OF PPE	A	-422	CAP REL COSTS-BLDG & FIXT	1.00	14 46.00
47.00		0		0.00	0 47.00
48.00		0		0.00	0 48.00
49.00		0		0.00	0 49.00
49.01		0		0.00	0 49.01
49.02		0		0.00	0 49.02
49.03		0		0.00	0 49.03
49.04		0		0.00	0 49.04
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,764,833			50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 150157

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

Worksheet A-8-1

Date/Time Prepared: 11/25/2014 3:49 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00	0	0	0	1.00
2.00	0.00	0	0	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT SVH CHARGEBACK	869,721	869,721	3.00
3.01	5.01	NONPATIENT TELEPHONES SVH CHARGEBACK	473,328	473,328	3.01
3.02	5.03	PURCHASING RECEIVING AND STORAGE SVH CHARGEBACK	603,247	603,247	3.02
3.03	5.04	PROPERTY ADMINISTRATION SVH CHARGEBACK	764,773	764,773	3.03
4.00	5.05	CASHIERING/ACCOUNTS RECEIVABLE SVH CHARGEBACK	1,419,626	1,419,626	4.00
4.01	5.07	OTHER ADMINISTRATIVE AND GENERAL SVH CHARGEBACK	330,180	330,180	4.01
4.02	13.00	NURSING ADMINISTRATION SVH CHARGEBACK	98,676	98,676	4.02
4.03	15.00	PHARMACY SVH CHARGEBACK	-14,196	-14,196	4.03
4.04	16.00	MEDICAL RECORDS & LIBRARY SVH CHARGEBACK	730,212	730,212	4.04
4.05	30.00	ADULTS & PEDIATRICS SVH CHARGEBACK	-972	-972	4.05
4.06	31.00	INTENSIVE CARE UNIT SVH CHARGEBACK	523,260	523,260	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC SVH CHARGEBACK	31,416	31,416	4.07
4.08	66.00	PHYSICAL THERAPY SVH CHARGEBACK	23,172	23,172	4.08
4.09	67.00	OCCUPATIONAL THERAPY SVH CHARGEBACK	-52,056	-52,056	4.09
4.10	69.00	ELECTROCARDIOLOGY SVH CHARGEBACK	88,080	88,080	4.10
4.11	194.06	SPORTS MEDICINE & OB PHYS SVH CHARGEBACK	210,072	210,072	4.11
4.12	4.00	EMPLOYEE BENEFITS DEPARTMENT SELF INSURANCE	6,165,171	5,354,001	4.12
4.13	1.00	CAP REL COSTS-BLDG & FIXTURE ASCENSION INTEREST	369,047	609,763	4.13
4.14	5.07	OTHER ADMINISTRATIVE AND GENERAL ASCENSION INTEREST	40,700	67,247	4.14
4.15	5.07	OTHER ADMINISTRATIVE AND GENERAL TRI MEDX	251,216	252,847	4.15
4.16	14.00	CENTRAL SERVICES & SUPPLY TRI MEDX	8,723	8,780	4.16
4.17	15.00	PHARMACY TRI MEDX	5,973	6,012	4.17
4.18	30.00	ADULTS & PEDIATRICS TRI MEDX	45,203	45,496	4.18
4.19	31.00	INTENSIVE CARE UNIT TRI MEDX	6,768	6,812	4.19
4.20	50.00	OPERATING ROOM TRI MEDX	70,805	71,265	4.20
4.21	54.00	RADIOLOGY-DIAGNOSTIC TRI MEDX	1,527,527	1,537,443	4.21
4.22	57.00	CT SCAN TRI MEDX	38,572	38,822	4.22
4.23	58.00	MAGNETIC RESONANCE IMAGING (TRI MEDX	3,748	3,772	4.23
4.24	65.00	RESPIRATORY THERAPY TRI MEDX	12,799	12,882	4.24
4.25	66.00	PHYSICAL THERAPY TRI MEDX	429	432	4.25
4.26	70.00	ELECTROENCEPHALOGRAPHY TRI MEDX	10,482	10,550	4.26
4.27	76.00	ENDOSCOPY TRI MEDX	6,621	6,664	4.27
4.28	91.00	EMERGENCY TRI MEDX	20,487	20,620	4.28
4.29	194.06	SPORTS MEDICINE & OB PHYS TRI MEDX	3,398	3,420	4.29
4.30	0.00		0	0	4.30
4.31	4.00	EMPLOYEE BENEFITS DEPARTMENT PENSION	1,679,595	862,306	4.31
4.32	4.00	EMPLOYEE BENEFITS DEPARTMENT SVH - EMPLOYEE BENEFITS - SALARY	134,996	0	4.32
4.33	4.00	EMPLOYEE BENEFITS DEPARTMENT SVH - EMPLOYEE BENEFITS - OTHER	986,080	653,971	4.33
4.34	5.01	NONPATIENT TELEPHONES SVH - PHONES - SALARIES	51,663	0	4.34
4.35	5.01	NONPATIENT TELEPHONES SVH - PHONES - OTHER	248,581	0	4.35
4.36	5.02	DATA PROCESSING SVH - DATA PROCESSING - SALARY	1,389,268	0	4.36
4.37	5.02	DATA PROCESSING SVH - DATA PROCESSING - OTHER	2,469,746	0	4.37
4.38	5.03	PURCHASING RECEIVING AND STORAGE SVH - PURCHASING - SALARIES	249,637	0	4.38
4.39	5.03	PURCHASING RECEIVING AND STORAGE SVH - PURCHASING - OTHER	224,559	0	4.39
4.40	5.04	PROPERTY ADMINISTRATION SVH - ADMINISTRATION - SALARIES	146,086	0	4.40
4.41	5.04	PROPERTY ADMINISTRATION SVH - ADMINISTRATION - OTHER	34,550	0	4.41
4.42	5.05	CASHIERING/ACCOUNTS RECEIVABLE SVH - CASHIERING - SALARIES	559,550	0	4.42
4.43	5.05	CASHIERING/ACCOUNTS RECEIVABLE SVH - CASHIERING - OTHER	907,441	0	4.43
4.44	5.06	OPERATION REGISTRATION SVH - OPERATION REGISTRATION - SALARY	69,333	0	4.44
4.45	5.06	OPERATION REGISTRATION SVH - OPERATION REGISTRATION - OTHER	3,520	0	4.45
4.46	5.07	OTHER ADMINISTRATIVE AND GENERAL SVH - A&G - SALARIES	1,283,784	1,434,043	4.46
4.47	5.07	OTHER ADMINISTRATIVE AND GENERAL SVH - A&G - OTHER	1,701,793	6,423,497	4.47
4.48	16.00	MEDICAL RECORDS & LIBRARY SVH - MED RECORDS - SALARIES	298,011	0	4.48
4.49	16.00	MEDICAL RECORDS & LIBRARY SVH - MED RECORDS - OTHER	144,176	0	4.49
4.50	194.01	MARKETING SVH - MARKETING - SALARIES	213,390	0	4.50
4.51	194.01	MARKETING SVH - MARKETING - OTHER	1,063,383	0	4.51
4.52	5.07	OTHER ADMINISTRATIVE AND GENERAL SVH - CAPITAL	2,027,354	0	4.52
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		30,572,704	23,529,184	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.

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

Provider CCN: 150157

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

Worksheet A-8-1

Date/Time Prepared:
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Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00

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

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

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

6.00	G	ST. VINCENT HEA	100.00	ST. VINCENT HEA	100.00	6.00
7.00	G	ASCENSION HEALT	100.00	ASCENSION HEALT	100.00	7.00
8.00	A	TRIMEDX	0.00	TRIMEDX	0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

(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: 150157

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

Worksheet A-8-1

Date/Time Prepared:
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0	1.00
2.00	0	0	2.00
3.00	0	0	3.00
3.01	0	0	3.01
3.02	0	0	3.02
3.03	0	0	3.03
4.00	0	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
4.03	0	0	4.03
4.04	0	0	4.04
4.05	0	0	4.05
4.06	0	0	4.06
4.07	0	0	4.07
4.08	0	0	4.08
4.09	0	0	4.09
4.10	0	0	4.10
4.11	0	0	4.11
4.12	811,170	0	4.12
4.13	-240,716	9	4.13
4.14	-26,547	0	4.14
4.15	-1,631	0	4.15
4.16	-57	0	4.16
4.17	-39	0	4.17
4.18	-293	0	4.18
4.19	-44	0	4.19
4.20	-460	0	4.20
4.21	-9,916	0	4.21
4.22	-250	0	4.22
4.23	-24	0	4.23
4.24	-83	0	4.24
4.25	-3	0	4.25
4.26	-68	0	4.26
4.27	-43	0	4.27
4.28	-133	0	4.28
4.29	-22	0	4.29
4.30	0	0	4.30
4.31	817,289	0	4.31
4.32	134,996	0	4.32
4.33	332,109	0	4.33
4.34	51,663	0	4.34
4.35	248,581	0	4.35
4.36	1,389,268	0	4.36
4.37	2,469,746	0	4.37
4.38	249,637	0	4.38
4.39	224,559	0	4.39
4.40	146,086	0	4.40
4.41	34,550	0	4.41
4.42	559,550	0	4.42
4.43	907,441	0	4.43
4.44	69,333	0	4.44
4.45	3,520	0	4.45
4.46	-150,259	0	4.46
4.47	-4,721,704	0	4.47
4.48	298,011	0	4.48
4.49	144,176	0	4.49
4.50	213,390	0	4.50
4.51	1,063,383	0	4.51
4.52	2,027,354	0	4.52
5.00	7,043,520		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	

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

Provider CCN: 150157

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

Worksheet A-8-1

Date/Time Prepared:
11/25/2014 3:49 pm

	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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOME OFFICE		6.00
7.00	HOME OFFICE		7.00
8.00	TECHNOLOGY MGMT		8.00
9.00			9.00
10.00			10.00
100.00			100.00

(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: 150157

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

Worksheet A-8-2

Date/Time Prepared:
11/25/2014 3:49 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.07	OTHER ADMINISTRATIVE AND GENERAL	172,535	172,535	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,895,618	1,895,618	0	0	0	2.00
3.00	35.00	SPECIAL CARE NURSERY	1,271,440	1,271,440	0	0	0	3.00
4.00	50.00	OPERATING ROOM	980,981	980,981	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	1,257,135	1,257,135	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	5,660	5,660	0	0	0	6.00
7.00	57.00	CT SCAN	4,000	4,000	0	0	0	7.00
8.00	91.00	EMERGENCY	40,000	40,000	0	0	0	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	197,539	197,539	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,824,908	5,824,908	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.07	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	35.00	SPECIAL CARE NURSERY	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.07	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	172,535		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,895,618		2.00
3.00	35.00	SPECIAL CARE NURSERY	0	0	0	1,271,440		3.00
4.00	50.00	OPERATING ROOM	0	0	0	980,981		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	1,257,135		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	5,660		6.00
7.00	57.00	CT SCAN	0	0	0	4,000		7.00
8.00	91.00	EMERGENCY	0	0	0	40,000		8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	197,539		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	5,824,908		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150157

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

Worksheet B
Part I
Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,855,079	4,855,079			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,631,734		2,631,734		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	13,973,164	63,891	0	14,037,055	4.00
5.01 00540	NONPATIENT TELEPHONES	920,981	13,650	0		934,631 5.01
5.02 00550	DATA PROCESSING	4,025,820	3,674	0	51,767	0 5.02
5.03 00561	PURCHASING RECEIVING AND STORES	1,452,218	18,124	0	188,768	6,547 5.03
5.04 00570	IP ADMINISTRATION	558,295	9,405	0	107,968	8,184 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	2,768,210	34,958	0	218,012	29,463 5.05
5.06 00571	OP REGISTRATION	814,674	24,312	0	186,120	16,368 5.06
5.07 00590	OTHER ADMINISTRATIVE AND GENERAL	1,341,644	204,345	251,265	1,064,835	42,558 5.07
7.00 00700	OPERATION OF PLANT	3,133,189	567,071	19,547	267,025	27,826 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	485,031	20,998	0	0	1,637 8.00
9.00 00900	HOUSEKEEPING	1,786,873	91,176	0	0	8,184 9.00
10.00 01000	DIETARY	827,107	106,638	6,387	0	8,184 10.00
11.00 01100	CAFETERIA	707,493	124,419	9,489	0	13,095 11.00
13.00 01300	NURSING ADMINISTRATION	1,629,303	2,237	10,484	489,432	22,916 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	318,633	108,157	18,145	92,406	19,642 14.00
15.00 01500	PHARMACY	4,491,907	85,118	0	650,773	40,921 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,147,147	4,947	0	109,154	4,910 16.00
17.00 01700	SOCIAL SERVICE	186,651	11,740	0	42,523	4,910 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,565,567	1,100,949	278,125	2,735,479	237,344 30.00
31.00 03100	INTENSIVE CARE UNIT	1,667,914	112,810	13,020	330,071	29,463 31.00
35.00 02040	SPECIAL CARE NURSERY	1,225,264	112,288	24,153	763,992	0 35.00
43.00 04300	NURSERY	1,137,081	199,593	2,594	321,718	16,368 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	11,639,880	432,888	854,553	1,241,862	91,663 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,070,821	229,947	1,929	525,416	93,299 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,898,733	254,749	257,522	654,821	37,647 54.00
54.02 05402	ULTRASOUND	121,489	33,619	7,607	20,588	1,637 54.02
57.00 05700	CT SCAN	202,357	12,801	30,473	51,138	1,637 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	658,826	130,101	190,039	115,637	8,184 58.00
60.00 06000	LABORATORY	2,617,636	78,815	0	19,704	0 60.00
65.00 06500	RESPIRATORY THERAPY	1,303,787	34,664	38,261	364,770	29,463 65.00
66.00 06600	PHYSICAL THERAPY	223,601	31,480	0	71,362	6,547 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	13,502	1,894	0	4,399	0 68.00
69.00 06900	ELECTROCARDIOLOGY	224,700	5,976	6,594	11,369	4,910 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	98,660	2,629	13,865	25,768	1,637 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,803,942	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	2,736,941	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00 07500	ASC (NON-DISTINCT PART)	13,482,968	206,990	434,309	564,594	0 75.00
76.00 03020	ENDOSCOPY	3,321,370	85,902	26,986	326,646	26,189 76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	2,139,557	222,306	16,425	546,381	68,747 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	106,209,749	4,785,261	2,511,772	12,164,498	910,080 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	400,032	27,006	9,062	23,918	4,910 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	316,666	0	0	101,240	0 192.00
194.00 07950	MISSION EFFECTIVENESS	577	0	4,393	0	0 194.00
194.01 07951	MARKETING	1,278,724	0	0	0	4,910 194.01
194.02 07952	JOINT VENTURES	135	0	0	0	0 194.02
194.04 07954	VACANT	0	14,450	0	0	0 194.04
194.06 07956	SPORTS MEDICINE & OB PHYS	6,686,116	28,362	106,507	1,747,399	14,731 194.06
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	114,891,999	4,855,079	2,631,734	14,037,055	934,631 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150157

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

Worksheet B Part I Date/Time Prepared: 11/25/2014 3:49 pm

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	I P ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	OP REGISTRATION	
			5.02	5.03	5.04	5.05	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	4,081,261					5.02
5.03	00561	PURCHASING RECEIVING AND STORES	11,259	1,676,916				5.03
5.04	00570	I P ADMINITTING	45,035	430	729,317			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	157,621	1,478	0	3,209,742		5.05
5.06	00571	OP REGISTRATION	90,069	843	0	0	1,132,386	5.06
5.07	00590	OTHER ADMINISTRATIVE AND GENERAL	416,570	1,906	0	0	0	5.07
7.00	00700	OPERATION OF PLANT	287,096	211	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,629	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	33,776	4,392	0	0	0	9.00
10.00	01000	DIETARY	22,517	148	0	0	0	10.00
11.00	01100	CAFETERIA	28,147	220	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	50,664	999	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	112,587	588	0	0	0	14.00
15.00	01500	PHARMACY	61,923	211,506	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	39,405	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	11,259	85	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	883,804	41,524	482,008	290,625	0	30.00
31.00	03100	INTENSIVE CARE UNIT	202,656	8,124	41,545	41,826	0	31.00
35.00	02040	SPECIAL CARE NURSERY	281,466	6,925	76,206	87,674	0	35.00
43.00	04300	NURSERY	22,517	7,145	129,558	72,391	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	388,423	660,238	0	922,946	335,134	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	140,733	34,805	0	215,309	4,165	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	197,026	31,945	0	144,364	82,044	54.00
54.02	05402	ULTRASOUND	5,629	17	0	27,601	15,910	54.02
57.00	05700	CT SCAN	11,259	535	0	66,763	36,673	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	22,517	4,616	0	32,653	21,107	58.00
60.00	06000	LABORATORY	11,259	22,071	0	226,066	82,843	60.00
65.00	06500	RESPIRATORY THERAPY	50,664	6,100	0	92,881	24,668	65.00
66.00	06600	PHYSICAL THERAPY	33,776	187	0	16,783	2,275	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	10	0	991	255	68.00
69.00	06900	ELECTROCARDIOLOGY	11,259	1,051	0	9,890	5,221	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,629	1,171	0	12,211	1,987	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	150,856	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	228,879	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	167,856	0	422,744	287,003	75.00
76.00	03020	ENDOSCOPY	39,405	40,755	0	142,517	90,876	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	332,130	21,926	0	250,457	142,225	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,013,709	1,659,542	729,317	3,076,692	1,132,386	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	577	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,517	74	0	133,050	0	192.00
194.00	07950	MISSION EFFECTIVENESS	11,259	0	0	0	0	194.00
194.01	07951	MARKETING	22,517	163	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	VACANT	0	0	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	11,259	16,560	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,081,261	1,676,916	729,317	3,209,742	1,132,386	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150157

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

Worksheet B
Part I
Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description		Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5A.06	5.07	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00561	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	IP ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00571	OP REGISTRATION					5.06
5.07	00590	OTHER ADMINISTRATIVE AND GENERAL	3,323,123	3,323,123			5.07
7.00	00700	OPERATION OF PLANT	4,301,965	128,134	4,430,099		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	513,295	15,288	23,757	552,340	8.00
9.00	00900	HOUSEKEEPING	1,924,401	57,318	103,154	0	2,084,873
10.00	01000	DIETARY	970,981	28,921	120,649	445	58,454
11.00	01100	CAFETERIA	882,863	26,296	140,766	661	68,200
13.00	01300	NURSING ADMINISTRATION	2,206,035	65,707	2,531	0	1,226
14.00	01400	CENTRAL SERVICES & SUPPLY	670,158	19,961	122,367	21,088	59,286
15.00	01500	PHARMACY	5,542,148	165,073	96,301	111	46,657
16.00	01600	MEDICAL RECORDS & LIBRARY	1,305,563	38,886	5,597	0	2,712
17.00	01700	SOCIAL SERVICE	257,168	7,660	13,282	0	6,435
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,615,425	405,535	1,245,593	206,395	603,485
31.00	03100	INTENSIVE CARE UNIT	2,447,429	72,897	127,631	25,295	61,837
35.00	02040	SPECIAL CARE NURSERY	2,577,968	76,785	127,040	0	61,550
43.00	04300	NURSERY	1,908,965	56,859	225,817	18,328	109,407
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,567,587	493,508	489,762	57,896	237,287
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,316,424	98,780	260,158	39,354	126,045
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,558,851	165,570	288,219	28,450	139,641
54.02	05402	ULTRASOUND	234,097	6,973	38,036	841	18,428
57.00	05700	CT SCAN	413,636	12,320	14,483	1,429	7,017
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,183,680	35,256	147,195	7,417	71,315
60.00	06000	LABORATORY	3,058,394	91,094	89,170	0	43,203
65.00	06500	RESPIRATORY THERAPY	1,945,258	57,940	39,219	754	19,001
66.00	06600	PHYSICAL THERAPY	386,011	11,497	35,616	52	17,256
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	21,051	627	2,143	3	1,038
69.00	06900	ELECTROCARDIOLOGY	280,970	8,369	6,761	130	3,276
70.00	07000	ELECTROENCEPHALOGRAPHY	163,557	4,872	2,974	57	1,441
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,954,798	58,224	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,965,820	88,337	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	15,566,464	463,647	234,185	54,077	113,461
76.00	03020	ENDOSCOPY	4,100,646	122,138	97,188	40,295	47,087
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,740,154	111,400	251,513	49,262	121,857
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	103,904,885	2,995,872	4,351,107	552,340	2,046,602
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	465,505	13,865	30,555	0	14,804
192.00	19200	PHYSICIANS' PRIVATE OFFICES	573,547	17,083	0	0	0
194.00	07950	MISSION EFFECTIVENESS	16,229	483	0	0	0
194.01	07951	MARKETING	1,306,314	38,909	0	0	0
194.02	07952	JOINT VENTURES	135	4	0	0	0
194.04	07954	VACANT	14,450	430	16,349	0	7,921
194.06	07956	SPORTS MEDICINE & OB PHYS	8,610,934	256,477	32,088	0	15,546
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	114,891,999	3,323,123	4,430,099	552,340	2,084,873

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150157

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

Worksheet B Part I Date/Time Prepared: 11/25/2014 3:49 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00561						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00571						5.06
5.07	00590						5.07
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	1,179,450					10.00
11.00	01100	0	1,118,786				11.00
13.00	01300	0	39,568	2,315,067			13.00
14.00	01400	0	18,486	1,950	913,296		14.00
15.00	01500	0	55,586	26	4,209	5,910,111	15.00
16.00	01600	0	14,426	0	0	0	16.00
17.00	01700	0	5,281	0	3	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,053,862	278,608	871,879	28,513	3,165	30.00
31.00	03100	57,875	31,837	119,699	5,211	1,997	31.00
35.00	02040	0	45,918	132,947	4,164	1,105	35.00
43.00	04300	0	36,407	125,834	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	138,265	454,067	431,688	472,422	50.00
52.00	05200	67,713	61,806	231,022	22,571	7,667	52.00
54.00	05400	0	73,013	8,366	14,023	3,172	54.00
54.02	05402	0	1,428	250	0	0	54.02
57.00	05700	0	4,868	421	90	0	57.00
58.00	05800	0	13,738	816	358	470	58.00
60.00	06000	0	2,016	8,454	169	50,172	60.00
65.00	06500	0	40,859	5	3,924	3,054	65.00
66.00	06600	0	7,761	0	129	20	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	426	0	0	0	68.00
69.00	06900	0	2,555	0	0	0	69.00
70.00	07000	0	2,538	0	399	0	70.00
71.00	07100	0	0	0	101,667	0	71.00
72.00	07200	0	0	0	154,249	0	72.00
73.00	07300	0	0	0	0	4,783,261	73.00
75.00	07500	0	0	0	98,362	403,572	75.00
76.00	03020	0	16,176	61,212	24,487	30,303	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	53,314	201,417	13,507	10,349	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		1,179,450	944,880	2,218,365	907,723	5,770,729	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	4,619	0	0	0	190.00
192.00	19200	0	9,451	0	36	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
194.04	07954	0	0	0	0	0	194.04
194.06	07956	0	159,836	96,702	5,537	139,382	194.06
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,179,450	1,118,786	2,315,067	913,296	5,910,111	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150157

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

Worksheet B
Part I
Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00561	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	IP ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00571	OP REGISTRATION						5.06
5.07	00590	OTHER ADMINISTRATIVE AND GENERAL						5.07
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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,367,184					16.00
17.00	01700	SOCIAL SERVICE	0	289,829				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	129,159	65,053	18,506,672	0	18,506,672	30.00
31.00	03100	INTENSIVE CARE UNIT	18,588	29,742	3,000,038	0	3,000,038	31.00
35.00	02040	SPECIAL CARE NURSERY	38,964	48,284	3,114,725	0	3,114,725	35.00
43.00	04300	NURSERY	32,172	0	2,513,789	0	2,513,789	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	410,020	5,694	19,758,196	0	19,758,196	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	95,687	36,667	4,363,894	0	4,363,894	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,158	0	6,343,463	0	6,343,463	54.00
54.02	05402	ULTRASOUND	12,266	0	312,319	0	312,319	54.02
57.00	05700	CT SCAN	29,671	0	483,935	0	483,935	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	14,511	0	1,474,756	0	1,474,756	58.00
60.00	06000	LABORATORY	100,468	0	3,443,140	0	3,443,140	60.00
65.00	06500	RESPIRATORY THERAPY	41,278	0	2,151,292	0	2,151,292	65.00
66.00	06600	PHYSICAL THERAPY	7,459	0	465,801	0	465,801	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	440	0	25,728	0	25,728	68.00
69.00	06900	ELECTROCARDIOLOGY	4,395	0	306,456	0	306,456	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,427	0	181,265	0	181,265	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,114,689	0	2,114,689	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,208,406	0	3,208,406	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,783,261	0	4,783,261	73.00
75.00	07500	ASC (NON-DISTINCT PART)	187,876	0	17,121,644	0	17,121,644	75.00
76.00	03020	ENDOSCOPY	63,337	15,184	4,618,053	0	4,618,053	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	111,308	74,000	4,738,081	0	4,738,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,367,184	274,624	103,029,603	0	103,029,603	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	529,348	0	529,348	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,205	615,322	0	615,322	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	16,712	0	16,712	194.00
194.01	07951	MARKETING	0	0	1,345,223	0	1,345,223	194.01
194.02	07952	JOINT VENTURES	0	0	139	0	139	194.02
194.04	07954	VACANT	0	0	39,150	0	39,150	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	0	9,316,502	0	9,316,502	194.06
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,367,184	289,829	114,891,999	0	114,891,999	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150157

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

Worksheet B Part II Date/Time Prepared: 11/25/2014 3:49 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	63,891	0	63,891	4.00
5.01 00540	NONPATIENT TELEPHONES	0	13,650	0	13,650	5.01
5.02 00550	DATA PROCESSING	0	3,674	0	3,674	5.02
5.03 00561	PURCHASING RECEIVING AND STORES	0	18,124	0	18,124	5.03
5.04 00570	IP ADMINISTRATION	0	9,405	0	9,405	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	34,958	0	34,958	5.05
5.06 00571	OP REGISTRATION	0	24,312	0	24,312	5.06
5.07 00590	OTHER ADMINISTRATIVE AND GENERAL	2,027,354	204,345	251,265	2,482,964	5.07
7.00 00700	OPERATION OF PLANT	0	567,071	19,547	586,618	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	20,998	0	20,998	8.00
9.00 00900	HOUSEKEEPING	0	91,176	0	91,176	9.00
10.00 01000	DIETARY	0	106,638	6,387	113,025	10.00
11.00 01100	CAFETERIA	0	124,419	9,489	133,908	11.00
13.00 01300	NURSING ADMINISTRATION	0	2,237	10,484	12,721	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	108,157	18,145	126,302	14.00
15.00 01500	PHARMACY	0	85,118	0	85,118	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	4,947	0	4,947	16.00
17.00 01700	SOCIAL SERVICE	0	11,740	0	11,740	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,100,949	278,125	1,379,074	30.00
31.00 03100	INTENSIVE CARE UNIT	0	112,810	13,020	125,830	31.00
35.00 02040	SPECIAL CARE NURSERY	0	112,288	24,153	136,441	35.00
43.00 04300	NURSERY	0	199,593	2,594	202,187	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	432,888	854,553	1,287,441	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	229,947	1,929	231,876	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	254,749	257,522	512,271	54.00
54.02 05402	ULTRASOUND	0	33,619	7,607	41,226	54.02
57.00 05700	CT SCAN	0	12,801	30,473	43,274	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	130,101	190,039	320,140	58.00
60.00 06000	LABORATORY	0	78,815	0	78,815	60.00
65.00 06500	RESPIRATORY THERAPY	0	34,664	38,261	72,925	65.00
66.00 06600	PHYSICAL THERAPY	0	31,480	0	31,480	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	1,894	0	1,894	68.00
69.00 06900	ELECTROCARDIOLOGY	0	5,976	6,594	12,570	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	2,629	13,865	16,494	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	206,990	434,309	641,299	75.00
76.00 03020	ENDOSCOPY	0	85,902	26,986	112,888	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	222,306	16,425	238,731	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,027,354	4,785,261	2,511,772	9,324,387	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	27,006	9,062	36,068	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	MISSION EFFECTIVENESS	0	0	4,393	4,393	194.00
194.01 07951	MARKETING	0	0	0	0	194.01
194.02 07952	JOINT VENTURES	0	0	0	0	194.02
194.04 07954	VACANT	0	14,450	0	14,450	194.04
194.06 07956	SPORTS MEDICINE & OB PHYS	0	28,362	106,507	134,869	194.06
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,027,354	4,855,079	2,631,734	9,514,167	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150157

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

Worksheet B
Part II
Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description		NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	I P ADMINITING	CASHIERING/ACCOUNTS RECEIVABLE	
		5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540	13,650					5.01
5.02	00550	0	3,910				5.02
5.03	00561	96	11	19,090			5.03
5.04	00570	120	43	5	10,064		5.04
5.05	00580	430	151	17	0	36,548	5.05
5.06	00571	239	86	10	0	0	5.06
5.07	00590	622	399	22	0	0	5.07
7.00	00700	406	275	2	0	0	7.00
8.00	00800	24	5	0	0	0	8.00
9.00	00900	120	32	50	0	0	9.00
10.00	01000	120	22	2	0	0	10.00
11.00	01100	191	27	3	0	0	11.00
13.00	01300	335	49	11	0	0	13.00
14.00	01400	287	108	7	0	0	14.00
15.00	01500	598	59	2,408	0	0	15.00
16.00	01600	72	38	0	0	0	16.00
17.00	01700	72	11	1	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,462	844	473	6,651	3,303	30.00
31.00	03100	430	194	92	573	475	31.00
35.00	02040	0	270	79	1,052	997	35.00
43.00	04300	239	22	81	1,788	823	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,339	372	7,514	0	10,555	50.00
52.00	05200	1,363	135	396	0	2,447	52.00
54.00	05400	550	189	364	0	1,641	54.00
54.02	05402	24	5	0	0	314	54.02
57.00	05700	24	11	6	0	759	57.00
58.00	05800	120	22	53	0	371	58.00
60.00	06000	0	11	251	0	2,570	60.00
65.00	06500	430	49	69	0	1,056	65.00
66.00	06600	96	32	2	0	191	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	11	68.00
69.00	06900	72	11	12	0	112	69.00
70.00	07000	24	5	13	0	139	70.00
71.00	07100	0	0	1,717	0	0	71.00
72.00	07200	0	0	2,606	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
75.00	07500	0	0	1,911	0	4,805	75.00
76.00	03020	382	38	464	0	1,620	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	1,004	318	250	0	2,847	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		13,291	3,844	18,891	10,064	35,036	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	72	0	7	0	0	190.00
192.00	19200	0	22	1	0	1,512	192.00
194.00	07950	0	11	0	0	0	194.00
194.01	07951	72	22	2	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.04	07954	0	0	0	0	0	194.04
194.06	07956	215	11	189	0	0	194.06
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		13,650	3,910	19,090	10,064	36,548	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part II Date/Time Prepared: 11/25/2014 3:49 pm		
Cost Center Description	OP REGISTRATION	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
	5.06	5.07	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00540	NONPATIENT TELEPHONES					5.01
5.02 00550	DATA PROCESSING					5.02
5.03 00561	PURCHASING RECEIVING AND STORES					5.03
5.04 00570	IP ADMITTING					5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 00571	OP REGISTRATION	25,494				5.06
5.07 00590	OTHER ADMINISTRATIVE AND GENERAL	0	2,488,854			5.07
7.00 00700	OPERATION OF PLANT	0	95,968	684,484		7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	11,451	3,671	36,149	8.00
9.00 00900	HOUSEKEEPING	0	42,930	15,938	0	150,246
10.00 01000	DIETARY	0	21,661	18,641	29	4,212
11.00 01100	CAFETERIA	0	19,695	21,749	43	4,915
13.00 01300	NURSING ADMINISTRATION	0	49,212	391	0	88
14.00 01400	CENTRAL SERVICES & SUPPLY	0	14,950	18,907	1,380	4,272
15.00 01500	PHARMACY	0	123,634	14,879	7	3,362
16.00 01600	MEDICAL RECORDS & LIBRARY	0	29,124	865	0	195
17.00 01700	SOCIAL SERVICE	0	5,737	2,052	0	464
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	303,733	192,453	13,510	43,492
31.00 03100	INTENSIVE CARE UNIT	0	54,597	19,720	1,655	4,456
35.00 02040	SPECIAL CARE NURSERY	0	57,509	19,629	0	4,436
43.00 04300	NURSERY	0	42,585	34,890	1,200	7,884
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	7,606	369,564	75,672	3,789	17,100
52.00 05200	DELIVERY ROOM & LABOR ROOM	93	73,983	40,196	2,576	9,083
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,841	124,007	44,532	1,862	10,063
54.02 05402	ULTRASOUND	357	5,222	5,877	55	1,328
57.00 05700	CT SCAN	823	9,227	2,238	94	506
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	474	26,406	22,743	485	5,139
60.00 06000	LABORATORY	1,859	68,227	13,777	0	3,113
65.00 06500	RESPIRATORY THERAPY	553	43,395	6,060	49	1,369
66.00 06600	PHYSICAL THERAPY	51	8,611	5,503	3	1,244
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	6	470	331	0	75
69.00 06900	ELECTROCARDIOLOGY	117	6,268	1,045	8	236
70.00 07000	ELECTROENCEPHALOGRAPHY	45	3,649	460	4	104
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	43,608	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	66,162	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00 07500	ASC (NON-DISTINCT PART)	6,439	347,257	36,183	3,539	8,177
76.00 03020	ENDOSCOPY	2,039	91,477	15,016	2,637	3,393
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	3,191	83,435	38,861	3,224	8,782
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	25,494	2,243,754	672,279	36,149	147,488
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,384	4,721	0	1,067
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	12,795	0	0	0
194.00 07950	MISSION EFFECTIVENESS	0	362	0	0	0
194.01 07951	MARKETING	0	29,141	0	0	0
194.02 07952	JOINT VENTURES	0	3	0	0	0
194.04 07954	VACANT	0	322	2,526	0	571
194.06 07956	SPORTS MEDICINE & OB PHYS	0	192,093	4,958	0	1,120
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	25,494	2,488,854	684,484	36,149	150,246

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150157

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

Worksheet B Part II Date/Time Prepared: 11/25/2014 3:49 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00561						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00571						5.06
5.07	00590						5.07
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	157,712					10.00
11.00	01100	0	180,531				11.00
13.00	01300	0	6,385	71,420			13.00
14.00	01400	0	2,983	60	169,677		14.00
15.00	01500	0	8,970	1	782	242,780	15.00
16.00	01600	0	2,328	0	0	0	16.00
17.00	01700	0	852	0	1	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	140,919	44,956	26,898	5,297	130	30.00
31.00	03100	7,739	5,137	3,693	968	82	31.00
35.00	02040	0	7,410	4,101	774	45	35.00
43.00	04300	0	5,875	3,882	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	22,311	14,008	80,205	19,406	50.00
52.00	05200	9,054	9,973	7,127	4,193	315	52.00
54.00	05400	0	11,782	258	2,605	130	54.00
54.02	05402	0	230	8	0	0	54.02
57.00	05700	0	786	13	17	0	57.00
58.00	05800	0	2,217	25	67	19	58.00
60.00	06000	0	325	261	31	2,061	60.00
65.00	06500	0	6,593	0	729	125	65.00
66.00	06600	0	1,252	0	24	1	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	69	0	0	0	68.00
69.00	06900	0	412	0	0	0	69.00
70.00	07000	0	410	0	74	0	70.00
71.00	07100	0	0	0	18,887	0	71.00
72.00	07200	0	0	0	28,656	0	72.00
73.00	07300	0	0	0	0	196,492	73.00
75.00	07500	0	0	0	18,273	16,578	75.00
76.00	03020	0	2,610	1,888	4,549	1,245	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	8,603	6,214	2,509	425	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		157,712	152,469	68,437	168,641	237,054	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	745	0	0	0	190.00
192.00	19200	0	1,525	0	7	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
194.04	07954	0	0	0	0	0	194.04
194.06	07956	0	25,792	2,983	1,029	5,726	194.06
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		157,712	180,531	71,420	169,677	242,780	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150157

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

Worksheet B
Part II
Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00561	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	IP ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00571	OP REGISTRATION						5.06
5.07	00590	OTHER ADMINISTRATIVE AND GENERAL						5.07
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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,066					16.00
17.00	01700	SOCIAL SERVICE	0	21,124				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,601	4,741	2,185,984	0	2,185,984	30.00
31.00	03100	INTENSIVE CARE UNIT	518	2,168	229,829	0	229,829	31.00
35.00	02040	SPECIAL CARE NURSERY	1,086	3,519	240,826	0	240,826	35.00
43.00	04300	NURSERY	897	0	303,817	0	303,817	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,382	415	1,934,332	0	1,934,332	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,667	2,672	400,541	0	400,541	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,789	0	716,865	0	716,865	54.00
54.02	05402	ULTRASOUND	342	0	55,082	0	55,082	54.02
57.00	05700	CT SCAN	827	0	58,838	0	58,838	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	405	0	379,212	0	379,212	58.00
60.00	06000	LABORATORY	2,801	0	174,192	0	174,192	60.00
65.00	06500	RESPIRATORY THERAPY	1,151	0	136,213	0	136,213	65.00
66.00	06600	PHYSICAL THERAPY	208	0	49,023	0	49,023	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12	0	2,888	0	2,888	68.00
69.00	06900	ELECTROCARDIOLOGY	123	0	21,038	0	21,038	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	151	0	21,689	0	21,689	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	64,212	0	64,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	97,424	0	97,424	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	196,492	0	196,492	73.00
75.00	07500	ASC (NON-DISTINCT PART)	5,237	0	1,092,268	0	1,092,268	75.00
76.00	03020	ENDOSCOPY	1,766	1,107	244,606	0	244,606	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,103	5,394	409,378	0	409,378	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	38,066	20,016	9,014,749	0	9,014,749	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	53,173	0	53,173	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,108	17,431	0	17,431	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	4,766	0	4,766	194.00
194.01	07951	MARKETING	0	0	29,237	0	29,237	194.01
194.02	07952	JOINT VENTURES	0	0	3	0	3	194.02
194.04	07954	VACANT	0	0	17,869	0	17,869	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	0	376,939	0	376,939	194.06
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	38,066	21,124	9,514,167	0	9,514,167	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150157

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

Worksheet B-1

Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONE LINES)	DATA PROCESSING (IS NODES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	297,347				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		2,090,617			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,913	0	43,083,893		4.00
5.01 00540	NONPATIENT TELEPHONES	836	0	0	571	5.01
5.02 00550	DATA PROCESSING	225	0	158,890	0	725 5.02
5.03 00561	PURCHASING RECEIVING AND STORES	1,110	0	579,385	4	2 5.03
5.04 00570	IP ADMINITTING	576	0	331,387	5	8 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	2,141	0	669,144	18	28 5.05
5.06 00571	OP REGISTRATION	1,489	0	571,258	10	16 5.06
5.07 00590	OTHER ADMINISTRATIVE AND GENERAL	12,515	199,602	3,268,299	26	74 5.07
7.00 00700	OPERATION OF PLANT	34,730	15,528	819,579	17	51 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,286	0	0	1	1 8.00
9.00 00900	HOUSEKEEPING	5,584	0	0	5	6 9.00
10.00 01000	DIETARY	6,531	5,074	0	5	4 10.00
11.00 01100	CAFETERIA	7,620	7,538	0	8	5 11.00
13.00 01300	NURSING ADMINISTRATION	137	8,328	1,502,216	14	9 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	6,624	14,414	283,623	12	20 14.00
15.00 01500	PHARMACY	5,213	0	1,997,419	25	11 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	303	0	335,028	3	7 16.00
17.00 01700	SOCIAL SERVICE	719	0	130,516	3	2 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	67,427	220,939	8,395,944	145	157 30.00
31.00 03100	INTENSIVE CARE UNIT	6,909	10,343	1,013,089	18	36 31.00
35.00 02040	SPECIAL CARE NURSERY	6,877	19,187	2,344,921	0	50 35.00
43.00 04300	NURSERY	12,224	2,061	987,451	10	4 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	26,512	678,846	3,811,649	56	69 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	14,083	1,532	1,612,660	57	25 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	15,602	204,572	2,009,842	23	35 54.00
54.02 05402	ULTRASOUND	2,059	6,043	63,191	1	1 54.02
57.00 05700	CT SCAN	784	24,207	156,957	1	2 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	150,965	354,924	5	4 58.00
60.00 06000	LABORATORY	4,827	0	60,476	0	2 60.00
65.00 06500	RESPIRATORY THERAPY	2,123	30,394	1,119,590	18	9 65.00
66.00 06600	PHYSICAL THERAPY	1,928	0	219,033	4	6 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	116	0	13,502	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	366	5,238	34,896	3	2 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	161	11,014	79,090	1	1 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00 07500	ASC (NON-DISTINCT PART)	12,677	345,010	1,732,908	0	0 75.00
76.00 03020	ENDOSCOPY	5,261	21,437	1,002,574	16	7 76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	13,615	13,048	1,677,009	42	59 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	293,071	1,995,320	37,336,450	556	713 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	7,199	73,412	3	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	310,735	0	4 192.00
194.00 07950	MISSION EFFECTIVENESS	0	3,490	0	0	2 194.00
194.01 07951	MARKETING	0	0	0	3	4 194.01
194.02 07952	JOINT VENTURES	0	0	0	0	0 194.02
194.04 07954	VACANT	885	0	0	0	0 194.04
194.06 07956	SPORTS MEDICINE & OB PHYS	1,737	84,608	5,363,296	9	2 194.06
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)	4,855,079	2,631,734	14,037,055	934,631	4,081,261 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	16.327991	1.258831	0.325807	1,636.831874	5,629.325517 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			63,891	13,650	3,910 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001483	23.905429	5.393103 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150157

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

Worksheet B-1

Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description		PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	IP ADMITTING (TOTAL PATIENT DAYS)	CASHIERING/ACCOUNTS RECEIVABLE (PATIENT REVENUE)	OP REGISTRATION (OP REVENUE)	Reconciliation	
		5.03	5.04	5.05	5.06	5A.07	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00561	20,052,654					5.03
5.04	00570	5,137	18,222				5.04
5.05	00580	17,676	0	364,826,356			5.05
5.06	00571	10,077	0	0	189,572,321		5.06
5.07	00590	22,788	0	0	0	-3,323,123	5.07
7.00	00700	2,522	0	0	0	0	7.00
8.00	00800	0	0	0	0	0	8.00
9.00	00900	52,521	0	0	0	0	9.00
10.00	01000	1,768	0	0	0	0	10.00
11.00	01100	2,627	0	0	0	0	11.00
13.00	01300	11,944	0	0	0	0	13.00
14.00	01400	7,026	0	0	0	0	14.00
15.00	01500	2,529,195	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	1,019	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	496,541	12,043	33,033,072	0	0	30.00
31.00	03100	97,145	1,038	4,754,003	0	0	31.00
35.00	02040	82,814	1,904	9,965,249	0	0	35.00
43.00	04300	85,444	3,237	8,228,130	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	7,895,203	0	104,904,272	56,096,580	0	50.00
52.00	05200	416,197	0	24,472,474	697,301	0	52.00
54.00	05400	382,004	0	16,408,742	13,735,775	0	54.00
54.02	05402	204	0	3,137,181	2,663,649	0	54.02
57.00	05700	6,397	0	7,588,375	6,139,787	0	57.00
58.00	05800	55,203	0	3,711,380	3,533,683	0	58.00
60.00	06000	263,925	0	25,695,130	13,869,661	0	60.00
65.00	06500	72,946	0	10,557,096	4,129,874	0	65.00
66.00	06600	2,238	0	1,907,614	380,810	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	117	0	112,583	42,655	0	68.00
69.00	06900	12,571	0	1,124,093	874,073	0	69.00
70.00	07000	13,999	0	1,387,879	332,651	0	70.00
71.00	07100	1,803,942	0	0	0	0	71.00
72.00	07200	2,736,941	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
75.00	07500	2,007,225	0	48,050,024	48,050,024	0	75.00
76.00	03020	487,346	0	16,198,814	15,214,528	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	262,194	0	28,467,487	23,811,270	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		19,844,896	18,222	349,703,598	189,572,321	-3,323,123	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	6,904	0	0	0	0	190.00
192.00	19200	882	0	15,122,758	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	1,951	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.04	07954	0	0	0	0	0	194.04
194.06	07956	198,021	0	0	0	0	194.06
200.00							200.00
201.00							201.00
202.00		1,676,916	729,317	3,209,742	1,132,386		202.00
203.00		0.083626	40.023982	0.008798	0.005973		203.00
204.00		19,090	10,064	36,548	25,494		204.00
205.00		0.000952	0.552299	0.000100	0.000134		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150157

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

Worksheet B-1

Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)		
		5.07	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00540	NONPATIENT TELEPHONES					5.01	
5.02	00550	DATA PROCESSING					5.02	
5.03	00561	PURCHASING RECEIVING AND STORES					5.03	
5.04	00570	IP ADMINISTRATION					5.04	
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05	
5.06	00571	OP REGISTRATION					5.06	
5.07	00590	OTHER ADMINISTRATIVE AND GENERAL	111,568,876				5.07	
7.00	00700	OPERATION OF PLANT	4,301,965	239,812			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	513,295	1,286	643,793		8.00	
9.00	00900	HOUSEKEEPING	1,924,401	5,584	0	232,942	9.00	
10.00	01000	DIETARY	970,981	6,531	519	6,531	42,919	10.00
11.00	01100	CAFETERIA	882,863	7,620	771	7,620	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,206,035	137	0	137	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	670,158	6,624	24,580	6,624	0	14.00
15.00	01500	PHARMACY	5,542,148	5,213	129	5,213	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,305,563	303	0	303	0	16.00
17.00	01700	SOCIAL SERVICE	257,168	719	0	719	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,615,425	67,427	240,567	67,427	38,349	30.00
31.00	03100	INTENSIVE CARE UNIT	2,447,429	6,909	29,483	6,909	2,106	31.00
35.00	02040	SPECIAL CARE NURSERY	2,577,968	6,877	0	6,877	0	35.00
43.00	04300	NURSERY	1,908,965	12,224	21,363	12,224	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,567,587	26,512	67,482	26,512	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,316,424	14,083	45,870	14,083	2,464	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,558,851	15,602	33,160	15,602	0	54.00
54.02	05402	ULTRASOUND	234,097	2,059	980	2,059	0	54.02
57.00	05700	CT SCAN	413,636	784	1,666	784	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,183,680	7,968	8,645	7,968	0	58.00
60.00	06000	LABORATORY	3,058,394	4,827	0	4,827	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,945,258	2,123	879	2,123	0	65.00
66.00	06600	PHYSICAL THERAPY	386,011	1,928	61	1,928	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	21,051	116	4	116	0	68.00
69.00	06900	ELECTROCARDIOLOGY	280,970	366	151	366	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	163,557	161	67	161	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,954,798	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,965,820	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	15,566,464	12,677	63,031	12,677	0	75.00
76.00	03020	ENDOSCOPY	4,100,646	5,261	46,967	5,261	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,740,154	13,615	57,418	13,615	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	100,581,762	235,536	643,793	228,666	42,919	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	465,505	1,654	0	1,654	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	573,547	0	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	16,229	0	0	0	0	194.00
194.01	07951	MARKETING	1,306,314	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	135	0	0	0	0	194.02
194.04	07954	VACANT	14,450	885	0	885	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	8,610,934	1,737	0	1,737	0	194.06
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)	3,323,123	4,430,099	552,340	2,084,873	1,179,450	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.029785	18.473217	0.857947	8.950181	27.480836	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,488,854	684,484	36,149	150,246	157,712	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.022308	2.854252	0.056150	0.644993	3.674643	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150157

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

Worksheet B-1
Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description		CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00561						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00571						5.06
5.07	00590						5.07
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,008,845					11.00
13.00	01300	35,680	445,263				13.00
14.00	01400	16,669	375	16,205,400			14.00
15.00	01500	50,124	5	74,676	2,716,625		15.00
16.00	01600	13,008	0	0	0	349,703,598	16.00
17.00	01700	4,762	0	49	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	251,231	167,691	505,934	1,455	33,033,072	30.00
31.00	03100	28,708	23,022	92,468	918	4,754,003	31.00
35.00	02040	41,406	25,570	73,883	508	9,965,249	35.00
43.00	04300	32,829	24,202	0	0	8,228,130	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	124,678	87,332	7,659,894	217,152	104,904,272	50.00
52.00	05200	55,732	44,433	400,496	3,524	24,472,474	52.00
54.00	05400	65,838	1,609	248,813	1,458	16,408,742	54.00
54.02	05402	1,288	48	0	0	3,137,181	54.02
57.00	05700	4,390	81	1,596	0	7,588,375	57.00
58.00	05800	12,388	157	6,361	216	3,711,380	58.00
60.00	06000	1,818	1,626	3,000	23,062	25,695,130	60.00
65.00	06500	36,844	1	69,620	1,404	10,557,096	65.00
66.00	06600	6,998	0	2,281	9	1,907,614	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	384	0	0	0	112,583	68.00
69.00	06900	2,304	0	0	0	1,124,093	69.00
70.00	07000	2,289	0	7,085	0	1,387,879	70.00
71.00	07100	0	0	1,803,942	0	0	71.00
72.00	07200	0	0	2,736,941	0	0	72.00
73.00	07300	0	0	0	2,198,660	0	73.00
75.00	07500	0	0	1,745,303	185,505	48,050,024	75.00
76.00	03020	14,586	11,773	434,489	13,929	16,198,814	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	48,075	38,739	239,671	4,757	28,467,487	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		852,029	426,664	16,106,502	2,652,557	349,703,598	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	4,165	0	0	0	0	190.00
192.00	19200	8,522	0	644	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
194.04	07954	0	0	0	0	0	194.04
194.06	07956	144,129	18,599	98,254	64,068	0	194.06
200.00							200.00
201.00							201.00
202.00		1,118,786	2,315,067	913,296	5,910,111	1,367,184	202.00
203.00		1.108977	5.199325	0.056358	2.175534	0.003910	203.00
204.00		180,531	71,420	169,677	242,780	38,066	204.00
205.00		0.178948	0.160400	0.010470	0.089368	0.000109	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150157

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

Worksheet C
Part I
Date/Time Prepared:
11/25/2014 3:49 pm

		Title XVIII		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,506,672		18,506,672	0	18,506,672	30.00
31.00	03100	INTENSIVE CARE UNIT	3,000,038		3,000,038	0	3,000,038	31.00
35.00	02040	SPECIAL CARE NURSERY	3,114,725		3,114,725	0	3,114,725	35.00
43.00	04300	NURSERY	2,513,789		2,513,789	0	2,513,789	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,758,196		19,758,196	0	19,758,196	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,363,894		4,363,894	0	4,363,894	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,343,463		6,343,463	0	6,343,463	54.00
54.02	05402	ULTRASOUND	312,319		312,319	0	312,319	54.02
57.00	05700	CT SCAN	483,935		483,935	0	483,935	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,474,756		1,474,756	0	1,474,756	58.00
60.00	06000	LABORATORY	3,443,140		3,443,140	0	3,443,140	60.00
65.00	06500	RESPIRATORY THERAPY	2,151,292	0	2,151,292	0	2,151,292	65.00
66.00	06600	PHYSICAL THERAPY	465,801	0	465,801	0	465,801	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	25,728	0	25,728	0	25,728	68.00
69.00	06900	ELECTROCARDIOLOGY	306,456		306,456	0	306,456	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	181,265		181,265	0	181,265	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,114,689		2,114,689	0	2,114,689	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,208,406		3,208,406	0	3,208,406	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,783,261		4,783,261	0	4,783,261	73.00
75.00	07500	ASC (NON-DISTINCT PART)	17,121,644		17,121,644	0	17,121,644	75.00
76.00	03020	ENDOSCOPY	4,618,053		4,618,053	0	4,618,053	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,738,081		4,738,081	0	4,738,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,747,934		2,747,934	0	2,747,934	92.00
200.00		Subtotal (see instructions)	105,777,537	0	105,777,537	0	105,777,537	200.00
201.00		Less Observation Beds	2,747,934		2,747,934	0	2,747,934	201.00
202.00		Total (see instructions)	103,029,603	0	103,029,603	0	103,029,603	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150157

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

Worksheet C
Part I
Date/Time Prepared:
11/25/2014 3:49 pm

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	28,258,826		28,258,826		30.00
31.00	03100	INTENSIVE CARE UNIT	4,754,003		4,754,003		31.00
35.00	02040	SPECIAL CARE NURSERY	9,965,249		9,965,249		35.00
43.00	04300	NURSERY	8,228,130		8,228,130		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	48,807,693	56,096,580	104,904,273	0.188345	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,775,173	697,301	24,472,474	0.178318	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,672,967	13,735,775	16,408,742	0.386590	54.00
54.02	05402	ULTRASOUND	473,532	2,663,649	3,137,181	0.099554	54.02
57.00	05700	CT SCAN	1,448,589	6,139,787	7,588,376	0.063773	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	177,697	3,533,683	3,711,380	0.397361	58.00
60.00	06000	LABORATORY	11,825,469	13,869,661	25,695,130	0.134000	60.00
65.00	06500	RESPIRATORY THERAPY	6,427,222	4,129,874	10,557,096	0.203777	65.00
66.00	06600	PHYSICAL THERAPY	1,526,804	380,810	1,907,614	0.244180	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	69,928	42,655	112,583	0.228525	68.00
69.00	06900	ELECTROCARDIOLOGY	250,020	874,073	1,124,093	0.272625	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,055,228	332,651	1,387,879	0.130606	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,549,541	12,193,870	29,743,411	0.071098	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,522,683	2,602,100	12,124,783	0.264616	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,856,924	8,732,909	24,589,833	0.194522	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	48,050,024	48,050,024	0.356330	75.00
76.00	03020	ENDOSCOPY	984,285	15,214,528	16,198,813	0.285086	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,656,217	23,811,270	28,467,487	0.166438	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	929,967	3,844,279	4,774,246	0.575574	92.00
200.00		Subtotal (see instructions)	199,216,147	216,945,479	416,161,626		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	199,216,147	216,945,479	416,161,626		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/25/2014 3:49 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
35.00	02040 SPECIAL CARE NURSERY		35.00
43.00	04300 NURSERY		43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.188345	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.178318	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.386590	54.00
54.02	05402 ULTRASOUND	0.099554	54.02
57.00	05700 CT SCAN	0.063773	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.397361	58.00
60.00	06000 LABORATORY	0.134000	60.00
65.00	06500 RESPIRATORY THERAPY	0.203777	65.00
66.00	06600 PHYSICAL THERAPY	0.244180	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0.228525	68.00
69.00	06900 ELECTROCARDIOLOGY	0.272625	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.130606	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.071098	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.264616	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.194522	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.356330	75.00
76.00	03020 ENDOSCOPY	0.285086	76.00
OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	0.166438	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.575574	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: 150157

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

Worksheet C
Part I
Date/Time Prepared:
11/25/2014 3:49 pm

		Title XIX		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,506,672		18,506,672	0	18,506,672	30.00
31.00	03100	INTENSIVE CARE UNIT	3,000,038		3,000,038	0	3,000,038	31.00
35.00	02040	SPECIAL CARE NURSERY	3,114,725		3,114,725	0	3,114,725	35.00
43.00	04300	NURSERY	2,513,789		2,513,789	0	2,513,789	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,758,196		19,758,196	0	19,758,196	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,363,894		4,363,894	0	4,363,894	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,343,463		6,343,463	0	6,343,463	54.00
54.02	05402	ULTRASOUND	312,319		312,319	0	312,319	54.02
57.00	05700	CT SCAN	483,935		483,935	0	483,935	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,474,756		1,474,756	0	1,474,756	58.00
60.00	06000	LABORATORY	3,443,140		3,443,140	0	3,443,140	60.00
65.00	06500	RESPIRATORY THERAPY	2,151,292	0	2,151,292	0	2,151,292	65.00
66.00	06600	PHYSICAL THERAPY	465,801	0	465,801	0	465,801	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	25,728	0	25,728	0	25,728	68.00
69.00	06900	ELECTROCARDIOLOGY	306,456		306,456	0	306,456	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	181,265		181,265	0	181,265	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,114,689		2,114,689	0	2,114,689	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,208,406		3,208,406	0	3,208,406	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,783,261		4,783,261	0	4,783,261	73.00
75.00	07500	ASC (NON-DISTINCT PART)	17,121,644		17,121,644	0	17,121,644	75.00
76.00	03020	ENDOSCOPY	4,618,053		4,618,053	0	4,618,053	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,738,081		4,738,081	0	4,738,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,747,934		2,747,934	0	2,747,934	92.00
200.00		Subtotal (see instructions)	105,777,537	0	105,777,537	0	105,777,537	200.00
201.00		Less Observation Beds	2,747,934		2,747,934	0	2,747,934	201.00
202.00		Total (see instructions)	103,029,603	0	103,029,603	0	103,029,603	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150157

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

Worksheet C
Part I
Date/Time Prepared:
11/25/2014 3:49 pm

		Title XIX			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	28,258,826		28,258,826		30.00
31.00	03100	INTENSIVE CARE UNIT	4,754,003		4,754,003		31.00
35.00	02040	SPECIAL CARE NURSERY	9,965,249		9,965,249		35.00
43.00	04300	NURSERY	8,228,130		8,228,130		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	48,807,693	56,096,580	104,904,273	0.188345	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,775,173	697,301	24,472,474	0.178318	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,672,967	13,735,775	16,408,742	0.386590	54.00
54.02	05402	ULTRASOUND	473,532	2,663,649	3,137,181	0.099554	54.02
57.00	05700	CT SCAN	1,448,589	6,139,787	7,588,376	0.063773	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	177,697	3,533,683	3,711,380	0.397361	58.00
60.00	06000	LABORATORY	11,825,469	13,869,661	25,695,130	0.134000	60.00
65.00	06500	RESPIRATORY THERAPY	6,427,222	4,129,874	10,557,096	0.203777	65.00
66.00	06600	PHYSICAL THERAPY	1,526,804	380,810	1,907,614	0.244180	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	69,928	42,655	112,583	0.228525	68.00
69.00	06900	ELECTROCARDIOLOGY	250,020	874,073	1,124,093	0.272625	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,055,228	332,651	1,387,879	0.130606	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,549,541	12,193,870	29,743,411	0.071098	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,522,683	2,602,100	12,124,783	0.264616	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,856,924	8,732,909	24,589,833	0.194522	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	48,050,024	48,050,024	0.356330	75.00
76.00	03020	ENDOSCOPY	984,285	15,214,528	16,198,813	0.285086	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,656,217	23,811,270	28,467,487	0.166438	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	929,967	3,844,279	4,774,246	0.575574	92.00
200.00		Subtotal (see instructions)	199,216,147	216,945,479	416,161,626		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	199,216,147	216,945,479	416,161,626		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/25/2014 3:49 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
35.00	02040	SPECIAL CARE NURSERY		35.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.02	05402	ULTRASOUND	0.000000	54.02
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	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
76.00	03020	ENDOSCOPY	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part I Date/Time Prepared: 11/25/2014 3:49 pm
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Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,185,984	0	2,185,984	14,143	154.56	30.00
31.00	INTENSIVE CARE UNIT	229,829		229,829	1,038	221.42	31.00
35.00	SPECIAL CARE NURSERY	240,826		240,826	1,904	126.48	35.00
43.00	NURSERY	303,817		303,817	3,237	93.86	43.00
200.00	Total (lines 30-199)	2,960,456		2,960,456	20,322		200.00

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	6.00	7.00	

INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	3,803	587,792	30.00
31.00	INTENSIVE CARE UNIT	364	80,597	31.00
35.00	SPECIAL CARE NURSERY	0	0	35.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	4,167	668,389	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part II Date/Time Prepared: 11/25/2014 3:49 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,934,332	104,904,273	0.018439	15,920,893	293,565	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	400,541	24,472,474	0.016367	1,374	22	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	716,865	16,408,742	0.043688	830,904	36,301	54.00
54.02	05402 ULTRASOUND	55,082	3,137,181	0.017558	103,294	1,814	54.02
57.00	05700 CT SCAN	58,838	7,588,376	0.007754	536,159	4,157	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	379,212	3,711,380	0.102175	78,512	8,022	58.00
60.00	06000 LABORATORY	174,192	25,695,130	0.006779	3,905,557	26,476	60.00
65.00	06500 RESPIRATORY THERAPY	136,213	10,557,096	0.012903	982,323	12,675	65.00
66.00	06600 PHYSICAL THERAPY	49,023	1,907,614	0.025699	847,142	21,771	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	2,888	112,583	0.025652	42,821	1,098	68.00
69.00	06900 ELECTROCARDIOLOGY	21,038	1,124,093	0.018716	128,894	2,412	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	21,689	1,387,879	0.015627	457,579	7,151	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	64,212	29,743,411	0.002159	5,450,415	11,767	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	97,424	12,124,783	0.008035	4,704,595	37,801	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	196,492	24,589,833	0.007991	4,468,501	35,708	73.00
75.00	07500 ASC (NON-DISTINCT PART)	1,092,268	48,050,024	0.022732	0	0	75.00
76.00	03020 ENDOSCOPY	244,606	16,198,813	0.015100	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	409,378	28,467,487	0.014381	1,976,426	28,423	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	324,583	4,774,246	0.067986	342,014	23,252	92.00
200.00	Total (lines 50-199)	6,378,876	364,955,418		40,777,403	552,415	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150157		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part III Date/Time Prepared: 11/25/2014 3:49 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02040	SPECIAL CARE NURSERY	0	0	0	0	0	35.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,143	0.00	3,803	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,038	0.00	364	0		31.00
35.00	02040	SPECIAL CARE NURSERY	1,904	0.00	0	0		35.00
43.00	04300	NURSERY	3,237	0.00	0	0		43.00
200.00		Total (lines 30-199)	20,322		4,167	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150157

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description			Title XVIII				Hospital	
			Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.02	05402	ULTRASOUND	0	0	0	0	0	54.02
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	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	ENDOSCOPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150157

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	104,904,273	0.000000	0.000000	15,920,893	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	24,472,474	0.000000	0.000000	1,374	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,408,742	0.000000	0.000000	830,904	54.00
54.02	05402	ULTRASOUND	0	3,137,181	0.000000	0.000000	103,294	54.02
57.00	05700	CT SCAN	0	7,588,376	0.000000	0.000000	536,159	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,711,380	0.000000	0.000000	78,512	58.00
60.00	06000	LABORATORY	0	25,695,130	0.000000	0.000000	3,905,557	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,557,096	0.000000	0.000000	982,323	65.00
66.00	06600	PHYSICAL THERAPY	0	1,907,614	0.000000	0.000000	847,142	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	112,583	0.000000	0.000000	42,821	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,124,093	0.000000	0.000000	128,894	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,387,879	0.000000	0.000000	457,579	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29,743,411	0.000000	0.000000	5,450,415	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,124,783	0.000000	0.000000	4,704,595	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,589,833	0.000000	0.000000	4,468,501	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	48,050,024	0.000000	0.000000	0	75.00
76.00	03020	ENDOSCOPY	0	16,198,813	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	28,467,487	0.000000	0.000000	1,976,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,774,246	0.000000	0.000000	342,014	92.00
200.00		Total (lines 50-199)	0	364,955,418			40,777,403	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150157

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	7,123,312	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	280	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,632,145	0	54.00
54.02	05402 ULTRASOUND	0	316,138	0	54.02
57.00	05700 CT SCAN	0	1,726,739	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	909,818	0	58.00
60.00	06000 LABORATORY	0	1,996,093	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	209,680	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	496	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	220,795	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	75,183	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,029,039	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	353,047	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	866,497	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03020 ENDOSCOPY	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0	5,040,789	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	754,039	0	92.00
200.00	Total (lines 50-199)	0	23,254,090	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/25/2014 3:49 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.188345	7,123,312	0	0	1,341,640	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.178318	280	0	0	50	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.386590	2,632,145	0	0	1,017,561	54.00
54.02 05402 ULTRASOUND	0.099554	316,138	0	0	31,473	54.02
57.00 05700 CT SCAN	0.063773	1,726,739	0	0	110,119	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.397361	909,818	0	0	361,526	58.00
60.00 06000 LABORATORY	0.134000	1,996,093	0	0	267,476	60.00
65.00 06500 RESPIRATORY THERAPY	0.203777	209,680	0	0	42,728	65.00
66.00 06600 PHYSICAL THERAPY	0.244180	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.228525	496	0	0	113	68.00
69.00 06900 ELECTROCARDIOLOGY	0.272625	220,795	0	0	60,194	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.130606	75,183	0	0	9,819	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.071098	1,029,039	38	0	73,163	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.264616	353,047	0	0	93,422	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.194522	866,497	0	15,764	168,553	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0.356330	0	0	0	0	75.00
76.00 03020 ENDOSCOPY	0.285086	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0.166438	5,040,789	0	0	838,979	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.575574	754,039	0	0	434,005	92.00
200.00 Subtotal (see instructions)		23,254,090	38	15,764	4,850,821	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		23,254,090	38	15,764	4,850,821	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/25/2014 3:49 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.02 05402 ULTRASOUND	0	0		54.02
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	3	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3,066		73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 03020 ENDOSCOPY	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	3	3,066		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	3	3,066		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/25/2014 3:49 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,143	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,143	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)		12,043	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,803	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		18,506,672	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		18,506,672	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		18,506,672	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,308.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,976,378	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)		4,976,378	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150157		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1	
		Title XVIII		Hospital		PPS	
Date/Time Prepared: 11/25/2014 3:49 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)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	3,000,038	1,038	2,890.21	364	1,052,036		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 SPECIAL CARE NURSERY	3,114,725	1,904	1,635.88	0	0		47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					7,458,275		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					13,486,689		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					668,389		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					552,415		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,220,804		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					12,265,885		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					2,100		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,308.54		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,747,934		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150157		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/25/2014 3:49 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,185,984	18,506,672	0.118119	2,747,934	324,583	90.00
91.00	Nursing School cost	0	18,506,672	0.000000	2,747,934	0	91.00
92.00	Allied health cost	0	18,506,672	0.000000	2,747,934	0	92.00
93.00	All other Medical Education	0	18,506,672	0.000000	2,747,934	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 11/25/2014 3:49 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,143	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,143	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)		12,043	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		458	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)		3,237	15.00
16.00	Nursery days (title V or XIX only)		50	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		18,506,672	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		18,506,672	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		18,506,672	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,308.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		599,311	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)		599,311	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/25/2014 3:49 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)		
42.00	NURSERY (title V & XIX only)	2,513,789	3,237	776.58	50	38,829	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3,000,038	1,038	2,890.21	59	170,522	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	SPECIAL CARE NURSERY	3,114,725	1,904	1,635.88	185	302,638	47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,471,896	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,583,196	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,100	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,308.54	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,747,934	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150157		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/25/2014 3:49 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,185,984	18,506,672	0.118119	2,747,934	324,583	90.00
91.00	Nursing School cost	0	18,506,672	0.000000	2,747,934	0	91.00
92.00	Allied health cost	0	18,506,672	0.000000	2,747,934	0	92.00
93.00	All other Medical Education	0	18,506,672	0.000000	2,747,934	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Prepared: 11/25/2014 3:49 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		7,434,003		30.00
31.00	03100 INTENSIVE CARE UNIT		1,711,164		31.00
35.00	02040 SPECIAL CARE NURSERY		0		35.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.188345	15,920,893	2,998,621	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.178318	1,374	245	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.386590	830,904	321,219	54.00
54.02	05402 ULTRASOUND	0.099554	103,294	10,283	54.02
57.00	05700 CT SCAN	0.063773	536,159	34,192	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.397361	78,512	31,198	58.00
60.00	06000 LABORATORY	0.134000	3,905,557	523,345	60.00
65.00	06500 RESPIRATORY THERAPY	0.203777	982,323	200,175	65.00
66.00	06600 PHYSICAL THERAPY	0.244180	847,142	206,855	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.228525	42,821	9,786	68.00
69.00	06900 ELECTROCARDIOLOGY	0.272625	128,894	35,140	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.130606	457,579	59,763	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.071098	5,450,415	387,514	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.264616	4,704,595	1,244,911	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.194522	4,468,501	869,222	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.356330	0	0	75.00
76.00	03020 ENDOSCOPY	0.285086	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.166438	1,976,426	328,952	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.575574	342,014	196,854	92.00
200.00	Total (sum of lines 50-94 and 96-98)		40,777,403	7,458,275	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		40,777,403		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Prepared: 11/25/2014 3:49 pm
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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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,646,810		30.00
31.00	03100 INTENSIVE CARE UNIT		538,936		31.00
35.00	02040 SPECIAL CARE NURSERY		1,248,484		35.00
43.00	04300 NURSERY		56,633		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.188345	2,383,717	448,961	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.178318	2,217,030	395,336	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.386590	151,411	58,534	54.00
54.02	05402 ULTRASOUND	0.099554	30,184	3,005	54.02
57.00	05700 CT SCAN	0.063773	65,449	4,174	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.397361	6,029	2,396	58.00
60.00	06000 LABORATORY	0.134000	680,548	91,193	60.00
65.00	06500 RESPIRATORY THERAPY	0.203777	452,251	92,158	65.00
66.00	06600 PHYSICAL THERAPY	0.244180	29,734	7,260	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.228525	444	101	68.00
69.00	06900 ELECTROCARDIOLOGY	0.272625	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.130606	2,480	324	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.071098	1,171,051	83,259	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.264616	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.194522	1,141,735	222,093	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.356330	0	0	75.00
76.00	03020 ENDOSCOPY	0.285086	82,513	23,523	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.166438	237,802	39,579	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.575574	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		8,652,378	1,471,896	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		8,652,378		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part A Date/Time Prepared: 11/25/2014 3:49 pm	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		2,936,951		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		7,337,308		1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0		1.03
2.00	Outlier payments for discharges. (see instructions)		228,447		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		147.25		4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.54		30.00
31.00	Percentage of Medicaid patient days (see instructions)		12.46		31.00
32.00	Sum of lines 30 and 31		15.00		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part A Date/Time Prepared: 11/25/2014 3:49 pm	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
33.00	Allowable disproportionate share percentage (see instructions)		2.50	1.01	33.00
34.00	Disproportionate share adjustment (see instructions)		119,282		34.00
			Prior to October 1	On/After October 1	
		0	1.00	1.01	2.00
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)				9,046,380,143 35.00
35.01	Factor 3 (see instructions)				0.000091381 35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)				826,667 35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)				618,301 35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		618,301		36.00
Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		1,094		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		11,240,289		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		11,240,289		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		866,311		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		12,106,600		59.00
60.00	Primary payer payments		3,862		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		12,102,738		61.00
62.00	Deductibles billed to program beneficiaries		1,050,944		62.00
63.00	Coinurance billed to program beneficiaries		13,776		63.00
64.00	Allowable bad debts (see instructions)		32,883		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		21,374		65.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part A Date/Time Prepared: 11/25/2014 3:49 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,301		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		11,059,392		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00			0		70.00
70.01			0		70.01
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		-11,885		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-587		70.94
70.95	Recovery of accelerated depreciation		0		70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,046,920		71.00
71.01	Sequestration adjustment (see instructions)		220,938		71.01
72.00	Interim payments		10,761,350		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		64,632		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0		75.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150157

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/25/2014 3:49 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013	1.01	2,936,951	0	2,936,951	0	2,936,951	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	7,337,308	0	0	7,337,308	7,337,308	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI	1.03	0	0	0	0	0	1.03
2.00	Outlier payments for discharges (see instructions)	2.00	228,447	0	66,271	162,176	228,447	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0250	0.0250	0.0250	0.0250		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	119,282	0	73,424	45,858	119,282	11.00
11.01	Uncompensated care payments	36.00	618,301	0	0	618,301	618,301	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,240,289	0	3,076,646	8,163,643	11,240,289	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	11,240,289	0	3,076,646	8,163,643	11,240,289	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	866,311	0	246,877	619,434	866,311	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,323,523	8,783,077	12,106,600	19.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150157

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/25/2014 3:49 pm

		Title XVIII		Hospital		PPS		
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	819,712	0	233,228	586,484	819,712	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	21,270	0	6,442	14,828	21,270	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0309	0.0309	0.0309	0.0309		24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	25,329	0	7,207	18,122	25,329	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	866,311	0	246,877	619,434	866,311	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.009821	0.000000		27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			32,640		32,640	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/25/2014 3:49 pm
		Title XVII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3,069 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			4,850,821 2.00
3.00	PPS payments			4,010,620 3.00
4.00	Outlier payment (see instructions)			35,348 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3,069 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			15,802 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)			15,802 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			15,802 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			12,733 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,069 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			4,045,968 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			8 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			954,096 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)			3,094,933 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)			3,094,933 30.00
31.00	Primary payer payments			1,138 31.00
32.00	Subtotal (line 30 minus line 31)			3,093,795 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			94,351 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			61,328 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			77,765 36.00
37.00	Subtotal (see instructions)			3,155,123 37.00
38.00	MSP-LCC reconciliation amount from PS&R			-31 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			3,155,154 40.00
40.01	Sequestration adjustment (see instructions)			63,103 40.01
41.00	Interim payments			3,029,420 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			62,631 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 150157		Period: From 07/01/2013 To 06/30/2014		Worksheet E-1 Part I Date/Time Prepared: 11/25/2014 3:49 pm	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		10,761,350		3,029,420	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		10,761,350		3,029,420	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		64,632		62,631	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		10,825,982		3,092,051	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet E-1 Part II Date/Time Prepared: 11/25/2014 3:49 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			6,137 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			4,167 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			890 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			14,985 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			416,161,626 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			7,032,147 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			771,807 8.00
9.00	Sequestration adjustment amount (see instructions)			15,436 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			756,371 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			819,784 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			-63,413 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 11/25/2014 3:49 pm	
		Title XIX	Hospital	Cost	
		Inpatient	Outpatient		
		1.00	2.00		
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	2,583,196			1.00
2.00	Medical and other services		0		2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	2,583,196	0		4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments		0		6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	2,583,196	0		7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	3,490,863			8.00
9.00	Ancillary service charges	8,652,378	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)	12,143,241	0		12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0		13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0		14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000		15.00
16.00	Total customary charges (see instructions)	12,143,241	0		16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	9,560,045	0		17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0		18.00
19.00	Interns and Residents (see instructions)	0	0		19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0		20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	2,583,196	0		21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0	0		22.00
23.00	Outlier payments	0	0		23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0	0		26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0		27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	2,583,196	0		29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	0	0		30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	2,583,196	0		31.00
32.00	Deductibles	0			32.00
33.00	Coinurance	0			33.00
34.00	Allowable bad debts (see instructions)	0			34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	2,583,196	0		36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0			37.00
38.00	Subtotal (line 36 ± line 37)	2,583,196	0		38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	2,583,196	0		40.00
41.00	Interim payments	2,583,196	0		41.00
42.00	Balance due provider/program (line 40 minus line 41)	0			42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0			43.00

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

Provider CCN: 150157

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

Worksheet G

Date/Time Prepared:
11/25/2014 3:49 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	5,432,907	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	51,263,309	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-23,253,729	0	0	0	6.00
7.00	Inventory	2,443,536	0	0	0	7.00
8.00	Prepaid expenses	279,340	0	0	0	8.00
9.00	Other current assets	1,765,264	0	0	0	9.00
10.00	Due from other funds	10,036,206	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	47,966,833	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,111,748	0	0	0	12.00
13.00	Land improvements	2,224,113	0	0	0	13.00
14.00	Accumulated depreciation	-2,094,992	0	0	0	14.00
15.00	Buildings	90,765,783	0	0	0	15.00
16.00	Accumulated depreciation	-38,078,201	0	0	0	16.00
17.00	Leasehold improvements	1,722,766	0	0	0	17.00
18.00	Accumulated depreciation	-1,507,319	0	0	0	18.00
19.00	Fixed equipment	2,791,447	0	0	0	19.00
20.00	Accumulated depreciation	-2,308,304	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	32,419,478	0	0	0	23.00
24.00	Accumulated depreciation	-27,095,424	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	60,951,095	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	612,987,386	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	29,112,863	217,241	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	642,100,249	217,241	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	751,018,177	217,241	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,492,435	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,367,840	0	0	0	38.00
39.00	Payroll taxes payable	172,013	0	0	0	39.00
40.00	Notes and loans payable (short term)	301,067	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	4,437,931	0	0	0	43.00
44.00	Other current liabilities	8,267,891	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,039,177	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	20,742,076	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20,742,076	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	39,781,253	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	711,236,924				52.00
53.00	Specific purpose fund		217,241			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	711,236,924	217,241	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	751,018,177	217,241	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150157

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

Worksheet G-1
Date/Time Prepared:
11/25/2014 3:49 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		603,652,195		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		138,403,360				2.00
3.00	Total (sum of line 1 and line 2)		742,055,555		0		3.00
4.00	RESTRICTED CONTRIBUTIONS USED FOR PR	1,241,843		0		0	4.00
5.00	OTHER ACTIVITY	13,383,877		1,273,761		0	5.00
6.00	GRANT REVENUE	0		20,000		0	6.00
7.00	RESTRICTED INCOME	0		7,975		0	7.00
8.00	RESTRICTED UNREALIZED GAIN	0		12,636		0	8.00
9.00	OTHER ADJUSTMENT	0		174,730		0	9.00
10.00	Total additions (sum of line 4-9)		14,625,720		1,489,102		10.00
11.00	Subtotal (line 3 plus line 10)		756,681,275		1,489,102		11.00
12.00	TRANSFER TO AFFILIATES	43,707,705		0		0	12.00
13.00	NET ASSETS RELEASED FROM RESTRICTION	0		1,271,861		0	13.00
14.00	OTHER ADJUSTMENT	0		0		0	14.00
15.00	OTHER ADJUSTMENT	1,736,646		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		45,444,351		1,271,861		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		711,236,924		217,241		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	RESTRICTED CONTRIBUTIONS USED FOR PR		0				4.00
5.00	OTHER ACTIVITY		0				5.00
6.00	GRANT REVENUE		0				6.00
7.00	RESTRICTED INCOME		0				7.00
8.00	RESTRICTED UNREALIZED GAIN		0				8.00
9.00	OTHER ADJUSTMENT		0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	TRANSFER TO AFFILIATES		0				12.00
13.00	NET ASSETS RELEASED FROM RESTRICTION		0				13.00
14.00	OTHER ADJUSTMENT		0				14.00
15.00	OTHER ADJUSTMENT		0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150157

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/25/2014 3:49 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	34,837,575		34,837,575	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	34,837,575		34,837,575	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,800,900		4,800,900	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	SPECIAL CARE NURSERY	9,965,249		9,965,249	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	14,766,149		14,766,149	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	49,603,724		49,603,724	17.00
18.00	Ancillary services	142,433,126	189,264,062	331,697,188	18.00
19.00	Outpatient services	5,159,895	29,700,818	34,860,713	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	PHYSICIAN PROFESSIONAL FEES	0	15,122,758	15,122,758	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	197,196,745	234,087,638	431,284,383	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		120,656,832		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)		120,656,832		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150157

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

Worksheet G-3

Date/Time Prepared:
11/25/2014 3:49 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	431,284,383	1.00
2.00	Less contractual allowances and discounts on patients' accounts	253,822,049	2.00
3.00	Net patient revenues (line 1 minus line 2)	177,462,334	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	120,656,832	4.00
5.00	Net income from service to patients (line 3 minus line 4)	56,805,502	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	23,779,542	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	535,295	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	306,189	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	460,987	22.00
23.00	Governmental appropriations	0	23.00
24.00	UNREALIZED GAIN ON INVESTMENTS	39,851,714	24.00
24.01	BILLING ARRANGEMENT REVENUE	1,414,114	24.01
24.02	MISCELLANEOUS REVENUE	3,662,753	24.02
24.03	GAIN ON SALE OF PPE	2,200	24.03
24.04	INCOME FROM UNCONSOLIDATED ENTITIES	989,181	24.04
24.05	NET ASSETS RELEASED FROM RESTRICTION	11,218,888	24.05
25.00	Total other income (sum of lines 6-24)	82,220,863	25.00
26.00	Total (line 5 plus line 25)	139,026,365	26.00
27.00	LOSS ON UNCONSOLIDATED ENTITIES	385,973	27.00
27.01	INTEREST RATE SWAP LOSS	853	27.01
27.02	RESTRUCTURING & NONRECURRING EXPENSE	50,179	27.02
27.03	DONATIONS	186,000	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	623,005	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	138,403,360	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150157	Period: From 07/01/2013 To 06/30/2014	Worksheet L Parts I-III Date/Time Prepared: 11/25/2014 3:49 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		819,712	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		21,270	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		43.53	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.54	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		12.46	8.00
9.00	Sum of lines 7 and 8		15.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.09	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		25,329	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		866,311	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00