

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: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet 5 Parts I-III Date/Time Prepared: 2/26/2014 10:56 am
--------------------------------------------------------------------------------------------	----------------------	---------------------------------------------	-------------------------------------------------------------------------

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: 2/26/2014 Time: 10:56 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HEART HOSPITAL AT DEACONESS GATEWAY (150175) for the cost reporting period beginning 10/01/2012 and ending 09/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information
 ECR: Date: 2/26/2014 Time: 10:56 am
 Y6vkw0tDGM7fCncSG10IFhLkQn7Gu0
 YN94w0p:HN4yfnjflvB00Qy.X:COHh
 OJEn0:YMaE00vMl2
 PI: Date: 2/26/2014 Time: 10:56 am
 LL5xVeUP::4oHGd3GSP99o1kz.rb0
 T:F7709GYu1bAy6QoTP.SJPbsC8yNz
 GaOU0mbgDX0m:PS0

(Signed) Rebecca L. Malotte
 Officer or Administrator of Provider(s)
Executive Director & CNO
 Title
February 26, 2014
 Date

	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	10,068	56,262	11,621	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	10,068	56,262	11,621	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150175			Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/26/2014 9:59 am				
1.00 Hospital and Hospital Health Care Complex Address:		2.00		3.00		4.00					
1.00	Street: 4007 GATEWAY BOULEVARD	PO Box:		Zip Code: 47630-		County: WARRICK				1.00	
2.00	City: NEWBURGH	State: IN								2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
3.00	Hospital and Hospital-Based Component Identification:										
	Hospital	HEART HOSPITAL AT DEACONESS GATEWAY	150175	21780	1	02/23/2009	N	P	P	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)					10/01/2012		09/30/2013		20.00	
21.00	Type of Control (see instructions)							4		21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N		N		22.00	
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		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				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0			24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0			25.00	
						Urban/Rural S		Date of Geogr			
						1.00		2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.							1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.							1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0		35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/26/2014 9:59 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N				39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 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)				0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150175		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/26/2014 9:59 am	
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	0	0	0.00	0.00	0.000000	65.00
				Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150175		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/26/2014 9:59 am	
	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	0	0.00	0.00	0.000000	67.00
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/26/2014 9:59 am		
		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	109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	37,548	0	0		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150175		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/26/2014 9:59 am								
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:	Contractor's Name:		Contractor's Number:		141.00								
142.00	Street:	PO Box:				142.00								
143.00	City:	State:		Zip Code:		143.00								
						1.00								
144.00	Are provider based physicians' costs included in Worksheet A?						Y 144.00							
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.						Y 145.00							
						1.00								
						2.00								
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N 146.00							
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N 147.00							
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N 148.00							
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N 149.00							
		Part A		Part B		Title V		Title XIX						
		1.00		2.00		3.00		4.00						
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)														
155.00	Hospital	N		N		N		N 155.00						
156.00	Subprovider - IPF	N		N		N		N 156.00						
157.00	Subprovider - IRF	N		N		N		N 157.00						
158.00	SUBPROVIDER							158.00						
159.00	SNF	N		N		N		N 159.00						
160.00	HOME HEALTH AGENCY	N		N		N		N 160.00						
161.00	CMHC			N		N		N 161.00						
						1.00								
Multi campus														
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N		165.00					
		Name		County		State		Zip Code		CBSA		FTE/Campus		
		0		1.00		2.00		3.00		4.00		5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5										0.00		166.00	
						1.00								
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act														
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y		167.00					
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0 168.00					
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.50		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)						10/01/2012		09/30/2013		170.00			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part II Date/Time Prepared: 2/26/2014 9:59 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		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)	N		N	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)	Y	02/07/2014	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150175		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part II Date/Time Prepared: 2/26/2014 9:59 am	
	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				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?					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.					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.					38.00	
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00	
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					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.	WENDY		FRUMKIN		41.00	
42.00	Enter the employer/company name of the cost report preparer.	DEACONESS HOSPITAL				42.00	
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	812-450-7423		WENDY.FRUMKIN@DEACONESS.COM		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)		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)	02/07/2014	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 COORDINATOR	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: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2014 9:59 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	24	8,760	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)		24	8,760	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		24	8,760	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)		24				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: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2014 9:59 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	3,410	137	5,910			1.00
2.00 HMO and other (see instructions)	692	74				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)	3,410	137	5,910			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	3,410	137	5,910	0.00	126.00	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	126.00	27.00
28.00 Observation Bed Days		32	646			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			66			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2014 9:59 am

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	829	28	1,574	1.00
2.00 HMO and other (see instructions)				194			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		829	28	1,574	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: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet S-3 Part II Date/Time Prepared: 2/26/2014 9:59 am			
	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	7,112,670	87,966	7,200,636	258,752.89	27.83	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		489,159	0	489,159	4,443.36	110.09	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		86,750	0	86,750	347.00	250.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		2,452,617	0	2,452,617			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		0	0	0			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	445,164	43,803	488,967	12,236.69	39.96	27.00
28.00	Administrative & General under contract (see inst.)		170,345	0	170,345	403.09	422.60	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		173,979	0	173,979	12,650.89	13.75	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		71,318	0	71,318	4,167.05	17.11	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150175			Period: From 10/01/2012 To 09/30/2013		Worksheet S-3 Part II Date/Time Prepared: 2/26/2014 9:59 am	
	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
42.00	Soci al Servi ce	17.00	0	0	0.00	0.00	0.00	42.00
43.00	Other General Servi ce	18.00	0	0	0.00	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-3
Part III
Date/Time Prepared:
2/26/2014 9:59 am

	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)	7,528,312	87,966	7,616,278	275,973.92	27.60	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	7,528,312	87,966	7,616,278	275,973.92	27.60	3.00
4.00	Subtotal other wages & related costs (see inst.)	575,909	0	575,909	4,790.36	120.22	4.00
5.00	Subtotal wage-related costs (see inst.)	2,452,617	0	2,452,617	0.00	32.20	5.00
6.00	Total (sum of lines 3 thru 5)	10,556,838	87,966	10,644,804	280,764.28	37.91	6.00
7.00	Total overhead cost (see instructions)	860,806	43,803	904,609	29,457.72	30.71	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet S-3 Part IV Date/Time Prepared: 2/26/2014 9:59 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			301,770 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)			227,627 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			898 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			32,917 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)			1,036,368 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			34,998 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			3,012 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			69 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			126,110 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			49,467 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			542,023 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			4,115 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			26,204 21.00
22.00	Day Care Cost and Allowances			49,242 22.00
23.00	Tuition Reimbursement			20,268 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			2,455,088 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet S-3 Part V Date/Time Prepared: 2/26/2014 9:59 am
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		489,159	2,452,617
2.00	Hospital		489,159	2,452,617
3.00	Subprovider - IPF			
4.00	Subprovider - IRF			
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA			
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	Renal Dialysis		0	0
18.00	Other		0	0

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet S-10 Date/Time Prepared: 2/26/2014 9:59 am
-----------------------------------------------	--	----------------------	---------------------------------------------	------------------------------------------------------------

				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)			0.254199	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			493,650	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			5,180,945	6.00	
7.00	Medicaid cost (line 1 times line 6)			1,316,991	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)			823,341	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			0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			823,341	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			2,783,038	155,139	2,938,177
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)			707,445	39,436	746,881
22.00	Partial payment by patients approved for charity care			18,140	0	18,140
23.00	Cost of charity care (line 21 minus line 22)			689,305	39,436	728,741
				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)					1,191,127
27.00	Medicare bad debts for the entire hospital complex (see instructions)					56,209
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)					1,134,918
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)					288,495
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)					1,017,236
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)					1,840,577

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet A
Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	0	2,711,588	2,711,588	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0	554,285	554,285	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,739,274	65,312	2,804,586	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	445,164	7,768,380	8,213,544	-2,902,333	5,311,211
7.00	00700	OPERATION OF PLANT	0	422,408	422,408	0	422,408
8.00	00800	LAUNDRY & LINEN SERVICE	0	77,244	77,244	0	77,244
9.00	00900	HOUSEKEEPING	0	159,884	159,884	0	159,884
10.00	01000	DIETARY	0	242,270	242,270	0	242,270
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	66,739	66,739	-285	66,454
14.00	01400	CENTRAL SERVICES & SUPPLY	0	305,412	305,412	-88,702	216,710
15.00	01500	PHARMACY	0	2,369,661	2,369,661	-1,666,939	702,722
16.00	01600	MEDICAL RECORDS & LIBRARY	0	519,903	519,903	0	519,903
17.00	01700	SOCIAL SERVICE	0	203,226	203,226	0	203,226
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,768,391	517,729	3,286,120	-186,048	3,100,072
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	522,077	4,606,138	5,128,215	-2,922,320	2,205,895
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,874	515,899	606,773	0	606,773
59.00	05900	CARDIAC CATHETERIZATION	2,129,030	10,088,809	12,217,839	-9,463,587	2,754,252
60.00	06000	LABORATORY	0	1,339,702	1,339,702	0	1,339,702
64.00	06400	INTRAVENOUS THERAPY	438,495	260,103	698,598	-195,157	503,441
65.00	06500	RESPIRATORY THERAPY	0	168,940	168,940	-8,293	160,647
66.00	06600	PHYSICAL THERAPY	0	148,995	148,995	0	148,995
69.00	06900	ELECTROCARDIOLOGY	472,551	388,401	860,952	-138,878	722,074
69.01	06902	CARDIAC REHAB	242,958	68,423	311,381	-23,431	287,950
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,538,781	3,538,781
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	9,083,124	9,083,124
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,651,335	1,651,335
74.00	07400	RENAL DIALYSIS	3,130	33,712	36,842	-8,452	28,390
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,112,670	33,011,252	40,123,922	0	40,123,922
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	VISITOR ASSISTANTS	0	23,650	23,650	0	23,650
194.02	07952	PUBLIC RELATIONS	0	6,727	6,727	0	6,727
200.00		TOTAL (SUM OF LINES 118-199)	7,112,670	33,041,629	40,154,299	0	40,154,299

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet A
Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	2,711,588	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-1,610	552,675	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,033,799	1,770,787	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-929,521	4,381,690	5.00
7.00	00700	OPERATION OF PLANT	0	422,408	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,778	105,022	8.00
9.00	00900	HOUSEKEEPING	0	159,884	9.00
10.00	01000	DIETARY	-62,873	179,397	10.00
11.00	01100	CAFETERIA	70,896	70,896	11.00
13.00	01300	NURSING ADMINISTRATION	0	66,454	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	216,710	14.00
15.00	01500	PHARMACY	0	702,722	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-43,894	476,009	16.00
17.00	01700	SOCIAL SERVICE	0	203,226	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	3,100,072	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,290,702	915,193	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-65,494	541,279	54.00
59.00	05900	CARDIAC CATHETERIZATION	-58,156	2,696,096	59.00
60.00	06000	LABORATORY	330,914	1,670,616	60.00
64.00	06400	INTRAVENOUS THERAPY	-3,516	499,925	64.00
65.00	06500	RESPIRATORY THERAPY	244,282	404,929	65.00
66.00	06600	PHYSICAL THERAPY	-87,166	61,829	66.00
69.00	06900	ELECTROCARDIOLOGY	-56,035	666,039	69.00
69.01	06902	CARDIAC REHAB	-8,319	279,631	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	113,099	3,651,880	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	9,083,124	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,651,335	73.00
74.00	07400	RENAL DIALYSIS	0	28,390	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,854,116	37,269,806	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	23,650	194.01
194.02	07952	PUBLIC RELATIONS	0	6,727	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-2,854,116	37,300,183	200.00

RECLASSIFICATIONS

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-6
Date/Time Prepared:
2/26/2014 9:59 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - EQUIPMENT DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	612,481	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
TOTALS			0	612,481	
B - LEASES					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,668,289	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,043,299	2.00
TOTALS			0	2,711,588	
C - INSURANCE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	21,457	1.00
TOTALS			0	21,457	
D - PROPERTY TAXES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	79,653	1.00
TOTALS			0	79,653	
E - SUPPLIES AND DRUGS CHARGED					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,538,781	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	9,083,124	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,651,335	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
TOTALS			0	14,273,240	
F - PROFESSIONAL FEES					
1.00	CARDIAC CATHETERIZATION	59.00	0	86,750	1.00
TOTALS			0	86,750	
G - INCENTIVE COMPENSATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	43,323	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	52,710	0	2.00
3.00	OPERATING ROOM	50.00	12,316	0	3.00
4.00	CARDIAC CATHETERIZATION	59.00	16,415	0	4.00
5.00	INTRAVENOUS THERAPY	64.00	3,245	0	5.00
6.00	ELECTROCARDIOLOGY	69.00	16,444	0	6.00
7.00	CARDIAC REHAB	69.01	6,695	0	7.00
TOTALS			151,148	0	
H - DISABILITY PAY					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	65,312	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
TOTALS			0	65,312	
I - SALARIES IN NON SALARY ACCOUNTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	480	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	480	0	2.00
3.00	CARDIAC CATHETERIZATION	59.00	440	0	3.00
4.00	ELECTROCARDIOLOGY	69.00	480	0	4.00
5.00	CARDIAC REHAB	69.01	250	0	5.00
TOTALS			2,130	0	
500.00	Grand Total: Increases		153,278	17,850,481	500.00

RECLASSIFICATIONS

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-6

Date/Time Prepared:
2/26/2014 9:59 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
A - EQUIPMENT DEPRECIATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	54,366	9		1.00
2.00	NURSING ADMINISTRATION	13.00	0	285	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	61,114	0		3.00
4.00	OPERATING ROOM	50.00	0	108,412	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	237,702	0		5.00
6.00	INTRAVENOUS THERAPY	64.00	0	8,342	0		6.00
7.00	ELECTROCARDIOLOGY	69.00	0	108,640	0		7.00
8.00	CARDIAC REHAB	69.01	0	25,168	0		8.00
9.00	RENAL DIALYSIS	74.00	0	8,452	0		9.00
	TOTALS		0	612,481			
B - LEASES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,711,588	10		1.00
2.00		0.00	0	0	10		2.00
	TOTALS		0	2,711,588			
C - INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	21,457	12		1.00
	TOTALS		0	21,457			
D - PROPERTY TAXES							
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	79,653	13		1.00
	TOTALS		0	79,653			
E - SUPPLIES AND DRUGS CHARGED							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	88,702	0		1.00
2.00	PHARMACY	15.00	0	1,666,939	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	147,037	0		3.00
4.00	OPERATING ROOM	50.00	0	2,826,224	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	9,299,454	0		5.00
6.00	INTRAVENOUS THERAPY	64.00	0	188,059	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	8,293	0		7.00
8.00	ELECTROCARDIOLOGY	69.00	0	45,071	0		8.00
9.00	CARDIAC REHAB	69.01	0	3,461	0		9.00
	TOTALS		0	14,273,240			
F - PROFESSIONAL FEES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	86,750	0		1.00
	TOTALS		0	86,750			
G - INCENTIVE COMPENSATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	151,148	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	TOTALS		0	151,148			
H - DISABILITY PAY							
1.00	ADULTS & PEDIATRICS	30.00	30,607	0	0		1.00
2.00	CARDIAC CATHETERIZATION	59.00	29,596	0	0		2.00
3.00	INTRAVENOUS THERAPY	64.00	2,001	0	0		3.00
4.00	ELECTROCARDIOLOGY	69.00	1,611	0	0		4.00
5.00	CARDIAC REHAB	69.01	1,497	0	0		5.00
	TOTALS		65,312	0	0		
I - SALARIES IN NON SALARY ACCOUNTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	480	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	480	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	440	0		3.00
4.00	ELECTROCARDIOLOGY	69.00	0	480	0		4.00
5.00	CARDIAC REHAB	69.01	0	250	0		5.00
	TOTALS		0	2,130			
500.00	Grand Total: Decreases		65,312	17,938,447			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-7
Part I
Date/Time Prepared:
2/26/2014 9:59 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	5,969,078	1,994,460	0	1,994,460	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	5,969,078	1,994,460	0	1,994,460	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	5,969,078	1,994,460	0	1,994,460	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	7,963,538	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	7,963,538	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	7,963,538	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-7
Part II
Date/Time Prepared:
2/26/2014 9:59 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-7
Part III
Date/Time Prepared:
2/26/2014 9:59 am

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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,994,460	0	1,994,460	1.000000	0	2.00
3.00	Total (sum of lines 1-2)	1,994,460	0	1,994,460	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	2,711,588	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	610,871	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	610,871	2,711,588	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	2,711,588	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	21,457	-79,653	0	552,675	2.00
3.00	Total (sum of lines 1-2)	0	21,457	-79,653	0	3,264,263	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-8

Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0			0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-92		ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	0	7.00
8.00 Television and radio service (chapter 21)		0			0.00	0	8.00
9.00 Parking lot (chapter 21)		0			0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-114,191				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-1,212,773				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests		0			0.00	0	14.00
15.00 Rental of quarters to employee and others		0			0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00 Sale of drugs to other than patients		0			0.00	0	17.00
18.00 Sale of medical records and abstracts		0			0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00 Vending machines		0			0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	B	-1,062		ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0		*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		*** Cost Center Deleted ***	0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0		*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0		ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0		*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00

Provider CCN: 150175

Period:
 From 10/01/2012
 To 09/30/2013

Worksheet A-8

Date/Time Prepared:
 2/26/2014 9:59 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.00 SERVICES TO OTHER ENTITIES	B	-3,516	INTRAVENOUS THERAPY	64.00	0	33.00
34.00 SELF INSURANCE	A	-1,033,799	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
35.00 RESEARCH	A	-487,073	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 GAIN ON EQUIPMENT DISPOSAL	A	-1,610	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
37.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	37.00
38.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	38.00
39.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	39.00
40.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	40.00
41.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	41.00
42.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42.00
43.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	43.00
44.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	44.00
45.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,854,116				50.00

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

Provider CCN: 150175

Period: From 10/01/2012 To 09/30/2013

Worksheet A-8-1

Date/Time Prepared: 2/26/2014 9:59 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX BUILDING LEASE	2,258,141	2,258,141	1.00
2.00	2.00	NEW CAP REL COSTS-MVBLE EQUI LEASES	300,057	300,057	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT BENEFITS	2,731,267	2,731,267	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL CONTRACT SERVICES	2,811,672	3,252,966	4.00
4.01	7.00	OPERATION OF PLANT CONTRACT SERVICES	178,360	178,360	4.01
4.02	8.00	LAUNDRY & LINEN SERVICE CONTRACT SERVICES	105,022	77,244	4.02
4.03	9.00	HOUSEKEEPING CONTRACT SERVICES	159,884	159,884	4.03
4.04	10.00	DIETARY CONTRACT SERVICES	179,397	242,270	4.04
4.05	11.00	CAFETERIA CONTRACT SERVICES	70,896	0	4.05
4.06	13.00	NURSING ADMINISTRATION CONTRACT SERVICES	66,454	66,454	4.06
4.07	14.00	CENTRAL SERVICES & SUPPLY CONTRACT SERVICES	174,379	174,379	4.07
4.08	15.00	PHARMACY CONTRACT SERVICES	691,477	691,477	4.08
4.09	16.00	MEDICAL RECORDS & LIBRARY CONTRACT SERVICES	476,009	519,903	4.09
4.10	17.00	SOCIAL SERVICE CONTRACT SERVICES	139,509	139,509	4.10
4.11	30.00	ADULTS & PEDIATRICS CONTRACT SERVICES	2,811,438	2,811,438	4.11
4.12	50.00	OPERATING ROOM CONTRACT SERVICES	566,537	1,857,239	4.12
4.13	54.00	RADIOLOGY-DIAGNOSTIC CONTRACT SERVICES	332,970	398,464	4.13
4.14	59.00	CARDIAC CATHETERIZATION CONTRACT SERVICES	2,197,504	2,197,504	4.14
4.15	60.00	LABORATORY CONTRACT SERVICES	1,670,616	1,339,702	4.15
4.16	64.00	INTRAVENOUS THERAPY CONTRACT SERVICES	673,983	673,983	4.16
4.17	65.00	RESPIRATORY THERAPY CONTRACT SERVICES	404,929	160,647	4.17
4.18	69.00	ELECTROCARDIOLOGY CONTRACT SERVICES	572,508	572,508	4.18
4.19	69.01	CARDIAC REHAB CONTRACT SERVICES	243,912	243,912	4.19
4.20	71.00	MEDICAL SUPPLIES CHARGED TO CONTRACT SERVICES	113,099	0	4.20
4.21	74.00	RENAL DIALYSIS CONTRACT SERVICES	3,131	3,131	4.21
4.23	69.01	CARDIAC REHAB FACILITY RENT	45,844	54,163	4.23
4.24	66.00	PHYSICAL THERAPY THERAPY SERVICES	61,829	148,995	4.24
5.00	0	0	20,040,824	21,253,597	5.00

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

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

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

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

6.00	B	51.00	DEACONESS HOSPITAL	0.00	6.00
7.00	B	51.00	DEACONESS HOSPITAL	0.00	7.00
8.00	B	51.00	DEACONESS HOSPITAL	0.00	8.00
9.00	B	51.00	DEACONESS HOSPITAL	0.00	9.00
10.00	B	51.00	DEACONESS HOSPITAL	0.00	10.00
10.01	B	51.00	DEACONESS HOSPITAL	0.00	10.01
10.02	B	51.00	DEACONESS HOSPITAL	0.00	10.02
10.03	B	51.00	DEACONESS HOSPITAL	0.00	10.03
10.04	B	51.00	DEACONESS HOSPITAL	0.00	10.04
10.05	B	51.00	DEACONESS HOSPITAL	0.00	10.05
10.06	B	51.00	DEACONESS HOSPITAL	0.00	10.06
10.07	B	51.00	DEACONESS HOSPITAL	0.00	10.07
10.08	B	51.00	DEACONESS HOSPITAL	0.00	10.08
10.09	B	51.00	DEACONESS HOSPITAL	0.00	10.09
10.10	B	51.00	DEACONESS HOSPITAL	0.00	10.10
10.11	B	51.00	DEACONESS HOSPITAL	0.00	10.11
10.12	B	51.00	DEACONESS HOSPITAL	0.00	10.12
10.13	B	51.00	DEACONESS HOSPITAL	0.00	10.13
10.14	B	51.00	DEACONESS HOSPITAL	0.00	10.14
10.15	B	51.00	DEACONESS HOSPITAL	0.00	10.15
10.16	B	51.00	DEACONESS HOSPITAL	0.00	10.16
10.17	B	51.00	DEACONESS HOSPITAL	0.00	10.17
10.18	B	51.00	DEACONESS HOSPITAL	0.00	10.18

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

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-8-1

Date/Time Prepared:
2/26/2014 9:59 am

	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	
10.19	B		51.00	DEACONESS HOSPITAL	0.00	10.19
10.20	B		51.00	DEACONESS HOSPI	0.00	10.20
10.21	B		51.00	DEACONESS HOSPI	0.00	10.21
10.22	B		51.00	DEAC HEALTH SYS	0.00	10.22
10.23	A		0.00	PROGRESSIVE HEA	51.00	10.23
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-8-1

Date/Time Prepared:
2/26/2014 9:59 am

	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	10		1.00
2.00	0	10		2.00
3.00	0	0		3.00
4.00	-441,294	0		4.00
4.01	0	0		4.01
4.02	27,778	0		4.02
4.03	0	0		4.03
4.04	-62,873	0		4.04
4.05	70,896	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	-43,894	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	-1,290,702	0		4.12
4.13	-65,494	0		4.13
4.14	0	0		4.14
4.15	330,914	0		4.15
4.16	0	0		4.16
4.17	244,282	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	113,099	0		4.20
4.21	0	0		4.21
4.23	-8,319	0		4.23
4.24	-87,166	0		4.24
5.00	-1,212,773			5.00

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

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

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

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

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

6.00	HOSPITAL		6.00
7.00	HOSPITAL		7.00
8.00	HOSPITAL		8.00
9.00	HOSPITAL		9.00
10.00	HOSPITAL		10.00
10.01	HOSPITAL		10.01
10.02	HOSPITAL		10.02
10.03	HOSPITAL		10.03
10.04	HOSPITAL		10.04
10.05	HOSPITAL		10.05
10.06	HOSPITAL		10.06
10.07	HOSPITAL		10.07
10.08	HOSPITAL		10.08
10.09	HOSPITAL		10.09
10.10	HOSPITAL		10.10
10.11	HOSPITAL		10.11
10.12	HOSPITAL		10.12
10.13	HOSPITAL		10.13
10.14	HOSPITAL		10.14
10.15	HOSPITAL		10.15
10.16	HOSPITAL		10.16
10.17	HOSPITAL		10.17
10.18	HOSPITAL		10.18

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

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-8-1

Date/Time Prepared:
2/26/2014 9:59 am

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
10.19	HOSPITAL		10.19
10.20	HOSPITAL		10.20
10.21	HOSPITAL		10.21
10.22	HEALTH SYSTEM		10.22
10.23	THERAPY PROVIDE		10.23
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: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-8-2

Date/Time Prepared:
2/26/2014 9:59 am

	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	59.00	AGGREGATE-CARDIAC CATHETERIZATION	86,750	0	86,750	171,400	347	1.00
2.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	56,035	56,035	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			142,785	56,035	86,750		347	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	59.00	AGGREGATE-CARDIAC CATHETERIZATION	28,594	1,430	0	0	0	1.00
2.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			28,594	1,430	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	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	28,594	58,156	58,156		1.00
2.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	56,035		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	28,594	58,156	114,191		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part I
Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	2,711,588	2,711,588			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	552,675		552,675		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,770,787	0	0	1,770,787	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,381,690	30,361	49,057	120,247	4,581,355
7.00 00700	OPERATION OF PLANT	422,408	31,584	0	0	453,992
8.00 00800	LAUNDRY & LINEN SERVICE	105,022	0	0	0	105,022
9.00 00900	HOUSEKEEPING	159,884	11,462	0	0	171,346
10.00 01000	DIETARY	179,397	0	0	0	179,397
11.00 01100	CAFETERIA	70,896	0	0	0	70,896
13.00 01300	NURSING ADMINISTRATION	66,454	0	257	0	66,711
14.00 01400	CENTRAL SERVICES & SUPPLY	216,710	0	0	0	216,710
15.00 01500	PHARMACY	702,722	0	0	0	702,722
16.00 01600	MEDICAL RECORDS & LIBRARY	476,009	0	0	0	476,009
17.00 01700	SOCIAL SERVICE	203,226	0	0	0	203,226
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,100,072	1,109,516	55,147	686,359	4,951,094
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	915,193	361,127	97,826	131,418	1,505,564
54.00 05400	RADIOLOGY-DIAGNOSTIC	541,279	0	0	22,348	563,627
59.00 05900	CARDIAC CATHETERIZATION	2,696,096	818,178	214,492	520,440	4,249,206
60.00 06000	LABORATORY	1,670,616	0	0	0	1,670,616
64.00 06400	INTRAVENOUS THERAPY	499,925	0	7,527	108,141	615,593
65.00 06500	RESPIRATORY THERAPY	404,929	0	0	0	404,929
66.00 06600	PHYSICAL THERAPY	61,829	0	0	0	61,829
69.00 06900	ELECTROCARDIOLOGY	666,039	349,360	98,032	119,976	1,233,407
69.01 06902	CARDIAC REHAB	279,631	0	22,710	61,088	363,429
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,651,880	0	0	0	3,651,880
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	9,083,124	0	0	0	9,083,124
73.00 07300	DRUGS CHARGED TO PATIENTS	1,651,335	0	0	0	1,651,335
74.00 07400	RENAL DIALYSIS	28,390	0	7,627	770	36,787
76.00 03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	37,269,806	2,711,588	552,675	1,770,787	37,269,806
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01 07951	VISITOR ASSISTANTS	23,650	0	0	0	23,650
194.02 07952	PUBLIC RELATIONS	6,727	0	0	0	6,727
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	37,300,183	2,711,588	552,675	1,770,787	37,300,183

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part I
Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,581,355				5.00
7.00	00700	OPERATION OF PLANT	63,569	517,561			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,705	0	119,727		8.00
9.00	00900	HOUSEKEEPING	23,992	2,239	0	197,577	9.00
10.00	01000	DIETARY	25,120	0	0	0	204,517
11.00	01100	CAFETERIA	9,927	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	9,341	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	30,344	0	0	0	0
15.00	01500	PHARMACY	98,397	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	66,652	0	0	0	0
17.00	01700	SOCIAL SERVICE	28,456	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	693,262	216,724	78,325	83,093	199,253
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	210,812	70,540	3,131	27,045	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	78,920	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	594,982	159,817	35,668	61,275	5,264
60.00	06000	LABORATORY	233,923	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	86,197	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	56,699	0	0	0	0
66.00	06600	PHYSICAL THERAPY	8,657	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	172,704	68,241	2,603	26,164	0
69.01	06902	CARDIAC REHAB	50,888	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	511,344	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,271,836	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	231,223	0	0	0	0
74.00	07400	RENAL DIALYSIS	5,151	0	0	0	0
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,577,101	517,561	119,727	197,577	204,517
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	VISITOR ASSISTANTS	3,312	0	0	0	0
194.02	07952	PUBLIC RELATIONS	942	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	4,581,355	517,561	119,727	197,577	204,517

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part I
Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		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
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	80,823					11.00
13.00	01300	0	76,052				13.00
14.00	01400	0	0	247,054			14.00
15.00	01500	0	0	0	801,119		15.00
16.00	01600	0	0	0	0	542,661	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	36,186	37,360	0	0	43,522	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,222	6,449	0	0	43,918	50.00
54.00	05400	947	0	0	0	31,313	54.00
59.00	05900	22,860	23,569	0	0	164,501	59.00
60.00	06000	0	0	0	0	32,744	60.00
64.00	06400	4,531	4,656	0	0	5,767	64.00
65.00	06500	0	0	0	0	5,737	65.00
66.00	06600	0	0	0	0	3,695	66.00
69.00	06900	6,222	0	0	0	53,873	69.00
69.01	06902	3,855	3,985	0	0	3,088	69.01
71.00	07100	0	0	69,265	0	50,699	71.00
72.00	07200	0	0	177,789	0	64,874	72.00
73.00	07300	0	0	0	801,119	38,056	73.00
74.00	07400	0	33	0	0	874	74.00
76.00	03020	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		80,823	76,052	247,054	801,119	542,661	118.00
NONREIMBURSABLE COST CENTERS							
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
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		80,823	76,052	247,054	801,119	542,661	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part I
Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE	231,682			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	225,720	6,564,539	0	6,564,539	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,873,681	0	1,873,681	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	674,807	0	674,807	54.00
59.00	05900	CARDIAC CATHETERIZATION	5,962	5,323,104	0	5,323,104	59.00
60.00	06000	LABORATORY	0	1,937,283	0	1,937,283	60.00
64.00	06400	INTRAVENOUS THERAPY	0	716,744	0	716,744	64.00
65.00	06500	RESPIRATORY THERAPY	0	467,365	0	467,365	65.00
66.00	06600	PHYSICAL THERAPY	0	74,181	0	74,181	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,563,214	0	1,563,214	69.00
69.01	06902	CARDIAC REHAB	0	425,245	0	425,245	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,283,188	0	4,283,188	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	10,597,623	0	10,597,623	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,721,733	0	2,721,733	73.00
74.00	07400	RENAL DIALYSIS	0	42,845	0	42,845	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	231,682	37,265,552	0	37,265,552	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	26,962	0	26,962	194.01
194.02	07952	PUBLIC RELATIONS	0	7,669	0	7,669	194.02
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	231,682	37,300,183	0	37,300,183	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part II
Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	30,361	49,057	79,418	5.00
7.00 00700	OPERATION OF PLANT	0	31,584	0	31,584	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	11,462	0	11,462	9.00
10.00 01000	DIETARY	0	0	0	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	257	257	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,109,516	55,147	1,164,663	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	361,127	97,826	458,953	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
59.00 05900	CARDIAC CATHETERIZATION	0	818,178	214,492	1,032,670	59.00
60.00 06000	LABORATORY	0	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	7,527	7,527	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	349,360	98,032	447,392	69.00
69.01 06902	CARDIAC REHAB	0	0	22,710	22,710	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	7,627	7,627	74.00
76.00 03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,711,588	552,675	3,264,263	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	VISITOR ASSISTANTS	0	0	0	0	194.01
194.02 07952	PUBLIC RELATIONS	0	0	0	0	194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	2,711,588	552,675	3,264,263	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150175		Period: From 10/01/2012 To 09/30/2013		Worksheet B Part II Date/Time Prepared: 2/26/2014 9:59 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	79,418				5.00
7.00	00700	OPERATION OF PLANT	1,102	32,686			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	255		255		8.00
9.00	00900	HOUSEKEEPING	416	141	0	12,019	9.00
10.00	01000	DIETARY	435	0	0	0	10.00
11.00	01100	CAFETERIA	172	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	162	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	526	0	0	0	14.00
15.00	01500	PHARMACY	1,706	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,155	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	493	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,016	13,687	166	5,055	424
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,654	4,455	7	1,645	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,368	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	10,313	10,093	76	3,727	11
60.00	06000	LABORATORY	4,055	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	1,494	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	983	0	0	0	0
66.00	06600	PHYSICAL THERAPY	150	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	2,993	4,310	6	1,592	0
69.01	06902	CARDIAC REHAB	882	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,863	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	22,055	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,008	0	0	0	0
74.00	07400	RENAL DIALYSIS	89	0	0	0	0
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	79,345	32,686	255	12,019	435
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	VISITOR ASSISTANTS	57	0	0	0	0
194.02	07952	PUBLIC RELATIONS	16	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	79,418	32,686	255	12,019	435

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150175		Period: From 10/01/2012 To 09/30/2013		Worksheet B Part II Date/Time Prepared: 2/26/2014 9:59 am		
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		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	
5.00	00500						5.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000						10.00	
11.00	01100	172					11.00	
13.00	01300	0	419				13.00	
14.00	01400	0	0	526			14.00	
15.00	01500	0	0	0	1,706		15.00	
16.00	01600	0	0	0	0	1,155	16.00	
17.00	01700	0	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	77	205	0	0	94	30.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	13	36	0	0	95	50.00	
54.00	05400	2	0	0	0	68	54.00	
59.00	05900	49	130	0	0	338	59.00	
60.00	06000	0	0	0	0	71	60.00	
64.00	06400	10	26	0	0	12	64.00	
65.00	06500	0	0	0	0	12	65.00	
66.00	06600	0	0	0	0	8	66.00	
69.00	06900	13	0	0	0	116	69.00	
69.01	06902	8	22	0	0	7	69.01	
71.00	07100	0	0	149	0	110	71.00	
72.00	07200	0	0	377	0	140	72.00	
73.00	07300	0	0	0	1,706	82	73.00	
74.00	07400	0	0	0	0	2	74.00	
76.00	03020	0	0	0	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS								
92.00	09200						92.00	
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)		172	419	526	1,706	1,155	118.00
NONREIMBURSABLE COST CENTERS								
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	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers		0	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)		172	419	526	1,706	1,155	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part II Date/Time Prepared: 2/26/2014 9:59 am		
Cost Center	Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	493			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	480	1,196,867	0	1,196,867
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	468,858	0	468,858
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,438	0	1,438
59.00	05900	CARDIAC CATHETERIZATION	13	1,057,420	0	1,057,420
60.00	06000	LABORATORY	0	4,126	0	4,126
64.00	06400	INTRAVENOUS THERAPY	0	9,069	0	9,069
65.00	06500	RESPIRATORY THERAPY	0	995	0	995
66.00	06600	PHYSICAL THERAPY	0	158	0	158
69.00	06900	ELECTROCARDIOLOGY	0	456,422	0	456,422
69.01	06902	CARDIAC REHAB	0	23,629	0	23,629
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,122	0	9,122
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	22,572	0	22,572
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,796	0	5,796
74.00	07400	RENAL DIALYSIS	0	7,718	0	7,718
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	493	3,264,190	0	3,264,190
NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	57	0	194.01
194.02	07952	PUBLIC RELATIONS	0	16	0	194.02
200.00		Cross Foot Adjustments		0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	493	3,264,263	0	3,264,263

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1
Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DEPRECIATION COST)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	53,229				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		612,481			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,200,636		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	596	54,366	488,967	-4,581,355	32,718,828 5.00
7.00 00700	OPERATION OF PLANT	620	0	0	0	453,992 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	105,022 8.00
9.00 00900	HOUSEKEEPING	225	0	0	0	171,346 9.00
10.00 01000	DIETARY	0	0	0	0	179,397 10.00
11.00 01100	CAFETERIA	0	0	0	0	70,896 11.00
13.00 01300	NURSING ADMINISTRATION	0	285	0	0	66,711 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	216,710 14.00
15.00 01500	PHARMACY	0	0	0	0	702,722 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	476,009 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	203,226 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	21,780	61,114	2,790,974	0	4,951,094 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	7,089	108,412	534,393	0	1,505,564 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	90,874	0	563,627 54.00
59.00 05900	CARDIAC CATHETERIZATION	16,061	237,702	2,116,289	0	4,249,206 59.00
60.00 06000	LABORATORY	0	0	0	0	1,670,616 60.00
64.00 06400	INTRAVENOUS THERAPY	0	8,342	439,739	0	615,593 64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	404,929 65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	61,829 66.00
69.00 06900	ELECTROCARDIOLOGY	6,858	108,640	487,864	0	1,233,407 69.00
69.01 06902	CARDIAC REHAB	0	25,168	248,406	0	363,429 69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,651,880 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	9,083,124 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,651,335 73.00
74.00 07400	RENAL DIALYSIS	0	8,452	3,130	0	36,787 74.00
76.00 03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	53,229	612,481	7,200,636	-4,581,355	32,688,451 118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01 07951	VISITOR ASSISTANTS	0	0	0	0	23,650 194.01
194.02 07952	PUBLIC RELATIONS	0	0	0	0	6,727 194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,711,588	552,675	1,770,787		4,581,355 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	50.941930	0.902355	0.245921		0.140022 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		79,418 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.002427 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1

Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	52,013				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	150,763			8.00
9.00	00900	HOUSEKEEPING	225	0	51,788		9.00
10.00	01000	DIETARY	0	0	0	19,269	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,780	98,628	21,780	18,773	535
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,089	3,943	7,089	0	92
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	14
59.00	05900	CARDIAC CATHETERIZATION	16,061	44,914	16,061	496	338
60.00	06000	LABORATORY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	67
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	6,858	3,278	6,858	0	92
69.01	06902	CARDIAC REHAB	0	0	0	0	57
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	52,013	150,763	51,788	19,269	1,195
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	517,561	119,727	197,577	204,517	80,823
203.00		Unit cost multiplier (Wkst. B, Part I)	9.950609	0.794140	3.815112	10.613784	67.634310
204.00		Cost to be allocated (per Wkst. B, Part II)	32,686	255	12,019	435	172
205.00		Unit cost multiplier (Wkst. B, Part II)	0.628420	0.001691	0.232081	0.022575	0.143933

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1
Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	226,590					13.00
14.00	01400	0	12,621,905				14.00
15.00	01500	0	0	1,651,335			15.00
16.00	01600	0	0	0	146,599,714		16.00
17.00	01700	0	0	0	0	6,801	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	111,312	0	0	11,756,361	6,626	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	19,213	0	0	11,863,194	0	50.00
54.00	05400	0	0	0	8,458,440	0	54.00
59.00	05900	70,221	0	0	44,449,430	175	59.00
60.00	06000	0	0	0	8,844,902	0	60.00
64.00	06400	13,872	0	0	1,557,762	0	64.00
65.00	06500	0	0	0	1,549,598	0	65.00
66.00	06600	0	0	0	998,156	0	66.00
69.00	06900	0	0	0	14,552,456	0	69.00
69.01	06902	11,874	0	0	834,230	0	69.01
71.00	07100	0	3,538,781	0	13,695,099	0	71.00
72.00	07200	0	9,083,124	0	17,524,130	0	72.00
73.00	07300	0	0	1,651,335	10,279,929	0	73.00
74.00	07400	98	0	0	236,027	0	74.00
76.00	03020	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		226,590	12,621,905	1,651,335	146,599,714	6,801	118.00
NONREIMBURSABLE COST CENTERS							
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
200.00							200.00
201.00							201.00
202.00		76,052	247,054	801,119	542,661	231,682	202.00
203.00		0.335637	0.019573	0.485134	0.003702	34.065873	203.00
204.00		419	526	1,706	1,155	493	204.00
205.00		0.001849	0.000042	0.001033	0.000008	0.072489	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/26/2014 9:59 am

		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	6,564,539	6,564,539	0	6,564,539	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,873,681	1,873,681	0	1,873,681	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	674,807	674,807	0	674,807	54.00
59.00	05900 CARDIAC CATHETERIZATION	5,323,104	5,323,104	58,156	5,381,260	59.00
60.00	06000 LABORATORY	1,937,283	1,937,283	0	1,937,283	60.00
64.00	06400 INTRAVENOUS THERAPY	716,744	716,744	0	716,744	64.00
65.00	06500 RESPIRATORY THERAPY	467,365	467,365	0	467,365	65.00
66.00	06600 PHYSICAL THERAPY	74,181	74,181	0	74,181	66.00
69.00	06900 ELECTROCARDIOLOGY	1,563,214	1,563,214	0	1,563,214	69.00
69.01	06902 CARDIAC REHAB	425,245	425,245	0	425,245	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,283,188	4,283,188	0	4,283,188	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	10,597,623	10,597,623	0	10,597,623	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,721,733	2,721,733	0	2,721,733	73.00
74.00	07400 RENAL DIALYSIS	42,845	42,845	0	42,845	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	646,840	646,840		646,840	92.00
200.00	Subtotal (see instructions)	37,912,392	37,912,392	58,156	37,970,548	200.00
201.00	Less Observation Beds	646,840	646,840		646,840	201.00
202.00	Total (see instructions)	37,265,552	37,265,552	58,156	37,323,708	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
		Hospital			PPS		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,883,469		10,883,469		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,626,229	236,966	11,863,195	0.157941	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,727,827	5,730,613	8,458,440	0.079779	54.00
59.00	05900	CARDIAC CATHETERIZATION	17,541,560	26,907,869	44,449,429	0.119756	59.00
60.00	06000	LABORATORY	7,402,221	1,442,681	8,844,902	0.219028	60.00
64.00	06400	INTRAVENOUS THERAPY	1,520,309	37,454	1,557,763	0.460111	64.00
65.00	06500	RESPIRATORY THERAPY	1,533,358	16,240	1,549,598	0.301604	65.00
66.00	06600	PHYSICAL THERAPY	972,642	25,513	998,155	0.074318	66.00
69.00	06900	ELECTROCARDIOLOGY	6,853,418	7,699,039	14,552,457	0.107419	69.00
69.01	06902	CARDIAC REHAB	0	834,230	834,230	0.509746	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,522,309	4,172,790	13,695,099	0.312753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,960,418	11,563,712	17,524,130	0.604745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,076,868	2,203,061	10,279,929	0.264762	73.00
74.00	07400	RENAL DIALYSIS	229,067	6,960	236,027	0.181526	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	194,977	677,915	872,892	0.741031	92.00
200.00		Subtotal (see instructions)	85,044,672	61,555,043	146,599,715		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	85,044,672	61,555,043	146,599,715		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/26/2014 9:59 am

Title XVIII

Hospital

PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.157941	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.079779	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.121065	59.00
60.00	06000 LABORATORY	0.219028	60.00
64.00	06400 INTRAVENOUS THERAPY	0.460111	64.00
65.00	06500 RESPIRATORY THERAPY	0.301604	65.00
66.00	06600 PHYSICAL THERAPY	0.074318	66.00
69.00	06900 ELECTROCARDIOLOGY	0.107419	69.00
69.01	06902 CARDIAC REHAB	0.509746	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.312753	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.604745	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.264762	73.00
74.00	07400 RENAL DIALYSIS	0.181526	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.741031	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: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	6,564,539		6,564,539	0	6,564,539	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,873,681		1,873,681	0	1,873,681	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	674,807		674,807	0	674,807	54.00
59.00	05900 CARDIAC CATHETERIZATION	5,323,104		5,323,104	58,156	5,381,260	59.00
60.00	06000 LABORATORY	1,937,283		1,937,283	0	1,937,283	60.00
64.00	06400 INTRAVENOUS THERAPY	716,744		716,744	0	716,744	64.00
65.00	06500 RESPIRATORY THERAPY	467,365	0	467,365	0	467,365	65.00
66.00	06600 PHYSICAL THERAPY	74,181	0	74,181	0	74,181	66.00
69.00	06900 ELECTROCARDIOLOGY	1,563,214		1,563,214	0	1,563,214	69.00
69.01	06902 CARDIAC REHAB	425,245		425,245	0	425,245	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,283,188		4,283,188	0	4,283,188	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	10,597,623		10,597,623	0	10,597,623	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,721,733		2,721,733	0	2,721,733	73.00
74.00	07400 RENAL DIALYSIS	42,845		42,845	0	42,845	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	646,840		646,840		646,840	92.00
200.00	Subtotal (see instructions)	37,912,392	0	37,912,392	58,156	37,970,548	200.00
201.00	Less Observation Beds	646,840		646,840		646,840	201.00
202.00	Total (see instructions)	37,265,552	0	37,265,552	58,156	37,323,708	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
		Title XIX			Hospital	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	10,883,469		10,883,469			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	11,626,229	236,966	11,863,195	0.157941	0.000000	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,727,827	5,730,613	8,458,440	0.079779	0.000000	54.00
59.00	05900 CARDIAC CATHETERIZATION	17,541,560	26,907,869	44,449,429	0.119756	0.000000	59.00
60.00	06000 LABORATORY	7,402,221	1,442,681	8,844,902	0.219028	0.000000	60.00
64.00	06400 INTRAVENOUS THERAPY	1,520,309	37,454	1,557,763	0.460111	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	1,533,358	16,240	1,549,598	0.301604	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	972,642	25,513	998,155	0.074318	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	6,853,418	7,699,039	14,552,457	0.107419	0.000000	69.00
69.01	06902 CARDIAC REHAB	0	834,230	834,230	0.509746	0.000000	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,522,309	4,172,790	13,695,099	0.312753	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	5,960,418	11,563,712	17,524,130	0.604745	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,076,868	2,203,061	10,279,929	0.264762	0.000000	73.00
74.00	07400 RENAL DIALYSIS	229,067	6,960	236,027	0.181526	0.000000	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	194,977	677,915	872,892	0.741031	0.000000	92.00
200.00	Subtotal (see instructions)	85,044,672	61,555,043	146,599,715			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	85,044,672	61,555,043	146,599,715			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.157941			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.079779			54.00
59.00	05900 CARDIAC CATHETERIZATION	0.121065			59.00
60.00	06000 LABORATORY	0.219028			60.00
64.00	06400 INTRAVENOUS THERAPY	0.460111			64.00
65.00	06500 RESPIRATORY THERAPY	0.301604			65.00
66.00	06600 PHYSICAL THERAPY	0.074318			66.00
69.00	06900 ELECTROCARDIOLOGY	0.107419			69.00
69.01	06902 CARDIAC REHAB	0.509746			69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.312753			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.604745			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.264762			73.00
74.00	07400 RENAL DIALYSIS	0.181526			74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.741031			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 150175

Period: From 10/01/2012 To 09/30/2013

Worksheet C Part II Date/Time Prepared: 2/26/2014 9:59 am

Cost Center Description		Title XIX			Hospital		PPS
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,873,681	468,858	1,404,823	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	674,807	1,438	673,369	0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	5,323,104	1,057,420	4,265,684	0	0	59.00
60.00	06000 LABORATORY	1,937,283	4,126	1,933,157	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	716,744	9,069	707,675	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	467,365	995	466,370	0	0	65.00
66.00	06600 PHYSICAL THERAPY	74,181	158	74,023	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	1,563,214	456,422	1,106,792	0	0	69.00
69.01	06902 CARDIAC REHAB	425,245	23,629	401,616	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,283,188	9,122	4,274,066	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	10,597,623	22,572	10,575,051	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,721,733	5,796	2,715,937	0	0	73.00
74.00	07400 RENAL DIALYSIS	42,845	7,718	35,127	0	0	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	646,840	117,934	528,906	0	0	92.00
200.00	Subtotal (sum of lines 50 thru 199)	31,347,853	2,185,257	29,162,596	0	0	200.00
201.00	Less Observation Beds	646,840	117,934	528,906	0	0	201.00
202.00	Total (line 200 minus line 201)	30,701,013	2,067,323	28,633,690	0	0	202.00

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

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part II
Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1,873,681	11,863,195	0.157941	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	674,807	8,458,440	0.079779	54.00
59.00	05900 CARDIAC CATHETERIZATION	5,323,104	44,449,429	0.119756	59.00
60.00	06000 LABORATORY	1,937,283	8,844,902	0.219028	60.00
64.00	06400 INTRAVENOUS THERAPY	716,744	1,557,763	0.460111	64.00
65.00	06500 RESPIRATORY THERAPY	467,365	1,549,598	0.301604	65.00
66.00	06600 PHYSICAL THERAPY	74,181	998,155	0.074318	66.00
69.00	06900 ELECTROCARDIOLOGY	1,563,214	14,552,457	0.107419	69.00
69.01	06902 CARDIAC REHAB	425,245	834,230	0.509746	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,283,188	13,695,099	0.312753	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	10,597,623	17,524,130	0.604745	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,721,733	10,279,929	0.264762	73.00
74.00	07400 RENAL DIALYSIS	42,845	236,027	0.181526	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	646,840	872,892	0.741031	92.00
200.00	Subtotal (sum of lines 50 thru 199)	31,347,853	135,716,246		200.00
201.00	Less Observation Beds	646,840	0		201.00
202.00	Total (line 200 minus line 201)	30,701,013	135,716,246		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150175		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part I Date/Time Prepared: 2/26/2014 9:59 am	
		Title XVIII		Hospital		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,196,867	0	1,196,867	6,556	182.56	30.00
200.00	Total (Lines 30-199)	1,196,867		1,196,867	6,556		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	3,410	622,530				
200.00	Total (Lines 30-199)	3,410	622,530				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part II
Date/Time Prepared:
2/26/2014 9:59 am

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	468,858	11,863,195	0.039522	6,088,393	240,625	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,438	8,458,440	0.000170	1,019,095	173	54.00
59.00	05900 CARDIAC CATHETERIZATION	1,057,420	44,449,429	0.023789	8,538,737	203,128	59.00
60.00	06000 LABORATORY	4,126	8,844,902	0.000466	4,569,659	2,129	60.00
64.00	06400 INTRAVENOUS THERAPY	9,069	1,557,763	0.005822	80,193	467	64.00
65.00	06500 RESPIRATORY THERAPY	995	1,549,598	0.000642	786,255	505	65.00
66.00	06600 PHYSICAL THERAPY	158	998,155	0.000158	686,666	108	66.00
69.00	06900 ELECTROCARDIOLOGY	456,422	14,552,457	0.031364	1,047,589	32,857	69.00
69.01	06902 CARDIAC REHAB	23,629	834,230	0.028324	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,122	13,695,099	0.000666	4,755,000	3,167	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	22,572	17,524,130	0.001288	3,336,482	4,297	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5,796	10,279,929	0.000564	4,475,214	2,524	73.00
74.00	07400 RENAL DIALYSIS	7,718	236,027	0.032700	161,399	5,278	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	117,934	872,892	0.135107	124,407	16,808	92.00
200.00	Total (Lines 50-199)	2,185,257	135,716,246		35,669,089	512,066	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150175		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part III Date/Time Prepared: 2/26/2014 9:59 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	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	6,556	0.00	3,410	0	0	30.00
200.00		Total (lines 30-199)	6,556		3,410	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/26/2014 9:59 am
----------------------------------------------------------------------------------	----------------------	---------------------------------------------	--------------------------------------------------------------------

Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06902	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
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: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/26/2014 9:59 am
----------------------------------------------------------------------------------	----------------------	---------------------------------------------	--------------------------------------------------------------------

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	11,863,195	0.000000	0.000000	6,088,393	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	8,458,440	0.000000	0.000000	1,019,095	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	44,449,429	0.000000	0.000000	8,538,737	59.00
60.00	06000 LABORATORY	0	8,844,902	0.000000	0.000000	4,569,659	60.00
64.00	06400 INTRAVENOUS THERAPY	0	1,557,763	0.000000	0.000000	80,193	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,549,598	0.000000	0.000000	786,255	65.00
66.00	06600 PHYSICAL THERAPY	0	998,155	0.000000	0.000000	686,666	66.00
69.00	06900 ELECTROCARDIOLOGY	0	14,552,457	0.000000	0.000000	1,047,589	69.00
69.01	06902 CARDIAC REHAB	0	834,230	0.000000	0.000000	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,695,099	0.000000	0.000000	4,755,000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	17,524,130	0.000000	0.000000	3,336,482	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	10,279,929	0.000000	0.000000	4,475,214	73.00
74.00	07400 RENAL DIALYSIS	0	236,027	0.000000	0.000000	161,399	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	872,892	0.000000	0.000000	124,407	92.00
200.00	Total (lines 50-199)	0	135,716,246			35,669,089	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/26/2014 9:59 am
----------------------------------------------------------------------------------	----------------------	---------------------------------------------	--------------------------------------------------------------------

Cost Center Description	Title XVIII					Hospital	PPS
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1		
	11.00	12.00	12.01	13.00	13.01		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	97,894	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	572,451	0	0	0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	11,750,175	0	0	0	0	59.00
60.00 06000 LABORATORY	0	36,993	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	3,716	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	8,922	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	1,143,274	0	0	0	0	69.00
69.01 06902 CARDIAC REHAB	0	422,882	0	0	0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,797,564	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	6,134,354	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	835,544	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	3,160	0	0	0	0	74.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	205,833	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	23,012,762	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/26/2014 9:59 am
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	1.00	2.00	2.01	3.00	4.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.157941	97,894	0	0	0 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.079779	572,451	0	0	0 54.00
59.00	05900 CARDIAC CATHETERIZATION	0.119756	11,750,175	0	0	8,948 59.00
60.00	06000 LABORATORY	0.219028	36,993	0	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	0.460111	3,716	0	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.301604	8,922	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.074318	0	0	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	0.107419	1,143,274	0	0	0 69.00
69.01	06902 CARDIAC REHAB	0.509746	422,882	0	0	0 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.312753	1,797,564	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.604745	6,134,354	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.264762	835,544	0	0	27,826 73.00
74.00	07400 RENAL DIALYSIS	0.181526	3,160	0	0	0 74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.741031	205,833	0	0	0 92.00
200.00	Subtotal (see instructions)		23,012,762	0	0	36,774 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		23,012,762	0	0	36,774 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150175		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part V Date/Time Prepared: 2/26/2014 9:59 am	
		Title XVIII		Hospital		PPS	
Cost Center Description		Costs					
		PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		5.00	5.01	6.00	7.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	15,461	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,670	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,407,154	0	0	1,072	59.00
60.00	06000	LABORATORY	8,103	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,710	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,691	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	122,809	0	0	0	69.00
69.01	06902	CARDIAC REHAB	215,562	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	562,194	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,709,720	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	221,220	0	0	7,367	73.00
74.00	07400	RENAL DIALYSIS	574	0	0	0	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	152,529	0	0	0	92.00
200.00		Subtotal (see instructions)	6,465,397	0	0	8,439	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	201.00
202.00		Net Charges (line 200 +/- line 201)	6,465,397	0	0	8,439	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150175		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part I Date/Time Prepared: 2/26/2014 9:59 am	
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)	PPS
Title XIX Hospital							
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,196,867	0	1,196,867	6,556	182.56	30.00
200.00	Total (Lines 30-199)	1,196,867		1,196,867	6,556		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	137	25,011				
200.00	Total (Lines 30-199)	137	25,011				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 150175		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part II Date/Time Prepared: 2/26/2014 9:59 am	
Cost Center Description			Title XIX		Hospital		PPS	
			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	468,858	11,863,195	0.039522	460,805	18,212	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,438	8,458,440	0.000170	52,756	9	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,057,420	44,449,429	0.023789	375,020	8,921	59.00
60.00	06000	LABORATORY	4,126	8,844,902	0.000466	288,736	135	60.00
64.00	06400	INTRAVENOUS THERAPY	9,069	1,557,763	0.005822	12,357	72	64.00
65.00	06500	RESPIRATORY THERAPY	995	1,549,598	0.000642	94,680	61	65.00
66.00	06600	PHYSICAL THERAPY	158	998,155	0.000158	23,022	4	66.00
69.00	06900	ELECTROCARDIOLOGY	456,422	14,552,457	0.031364	58,607	1,838	69.00
69.01	06902	CARDIAC REHAB	23,629	834,230	0.028324	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,122	13,695,099	0.000666	206,736	138	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	22,572	17,524,130	0.001288	107,224	138	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,796	10,279,929	0.000564	335,366	189	73.00
74.00	07400	RENAL DIALYSIS	7,718	236,027	0.032700	0	0	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	117,934	872,892	0.135107	1,948	263	92.00
200.00		Total (Lines 50-199)	2,185,257	135,716,246		2,017,257	29,980	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150175		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part III Date/Time Prepared: 2/26/2014 9:59 am	
Cost Center Description			Title XIX		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
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	6,556	0.00	137	0		30.00
200.00		Total (lines 30-199)	6,556		137	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/26/2014 9:59 am
----------------------------------------------------------------------------------	----------------------	---------------------------------------------	--------------------------------------------------------------------

Cost Center Description	Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06902	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
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: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/26/2014 9:59 am
----------------------------------------------------------------------------------	----------------------	---------------------------------------------	--------------------------------------------------------------------

Cost Center Description		Title XIX			Hospital		PPS	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	11,863,195	0.000000	0.000000	460,805	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,458,440	0.000000	0.000000	52,756	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	44,449,429	0.000000	0.000000	375,020	59.00
60.00	06000	LABORATORY	0	8,844,902	0.000000	0.000000	288,736	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,557,763	0.000000	0.000000	12,357	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,549,598	0.000000	0.000000	94,680	65.00
66.00	06600	PHYSICAL THERAPY	0	998,155	0.000000	0.000000	23,022	66.00
69.00	06900	ELECTROCARDIOLOGY	0	14,552,457	0.000000	0.000000	58,607	69.00
69.01	06902	CARDIAC REHAB	0	834,230	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,695,099	0.000000	0.000000	206,736	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	17,524,130	0.000000	0.000000	107,224	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,279,929	0.000000	0.000000	335,366	73.00
74.00	07400	RENAL DIALYSIS	0	236,027	0.000000	0.000000	0	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	872,892	0.000000	0.000000	1,948	92.00
200.00		Total (Lines 50-199)	0	135,716,246			2,017,257	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description			Title XIX			Hospital		PPS
			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
			11.00	12.00	12.01	13.00	13.01	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06902	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
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 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/26/2014 9:59 am
	Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	1.00	2.00	2.01	3.00	4.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.157941	0	0	0	26,114	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.079779	0	0	0	67,152	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.119756	0	0	0	1,309,854	59.00
60.00	06000	LABORATORY	0.219028	0	0	0	90,649	60.00
64.00	06400	INTRAVENOUS THERAPY	0.460111	0	0	0	111	64.00
65.00	06500	RESPIRATORY THERAPY	0.301604	0	0	0	66	65.00
66.00	06600	PHYSICAL THERAPY	0.074318	0	0	0	2,518	66.00
69.00	06900	ELECTROCARDIOLOGY	0.107419	0	0	0	342,820	69.00
69.01	06902	CARDIAC REHAB	0.509746	0	0	0	5,658	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.312753	0	0	0	166,945	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.604745	0	0	0	600,617	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264762	0	0	0	106,494	73.00
74.00	07400	RENAL DIALYSIS	0.181526	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.741031	0	0	0	47,135	92.00
200.00		Subtotal (see instructions)		0	0	0	2,766,133	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	2,766,133	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/26/2014 9:59 am
	Title XIX	Hospital	PPS

Cost Center Description	Costs						
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	5.00	5.01	6.00	7.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	4,124	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,357	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	156,863	59.00
60.00	06000	LABORATORY	0	0	0	19,855	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	51	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	20	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	187	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	36,825	69.00
69.01	06902	CARDIAC REHAB	0	0	0	2,884	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	52,213	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	363,220	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,196	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	34,928	92.00
200.00		Subtotal (see instructions)	0	0	0	704,723	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	0	704,723	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/26/2014 9:59 am
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)		6,556	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,556	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)		5,910	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)		3,410	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)		6,564,539	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)		6,564,539	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)		6,564,539	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)		1,001.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,414,433	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)		3,414,433	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/26/2014 9:59 am
Cost Center Description			Title XVIII	Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				8,326,349
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				11,740,782
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				622,530
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				512,066
52.00	Total Program excludable cost (sum of lines 50 and 51)				1,134,596
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				10,606,186
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00
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
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
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)				646
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,001.30
89.00	Observation bed cost (line 87 x line 88) (see instructions)				646,840

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150175		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/26/2014 9:59 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,196,867	6,564,539	0.182323	646,840	117,934	90.00
91.00	Nursing School cost	0	6,564,539	0.000000	646,840	0	91.00
92.00	Allied health cost	0	6,564,539	0.000000	646,840	0	92.00
93.00	All other Medical Education	0	6,564,539	0.000000	646,840	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 2/26/2014 9:59 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,556	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,556	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)		5,910	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)		137	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)		6,564,539	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)		6,564,539	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)		6,564,539	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)		1,001.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		137,178	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)		137,178	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/26/2014 9:59 am
Cost Center Description			Title XIX	Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				447,617
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				584,795
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				25,011
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				29,980
52.00	Total Program excludable cost (sum of lines 50 and 51)				54,991
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				529,804
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00
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
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
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)				646
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,001.30
89.00	Observation bed cost (line 87 x line 88) (see instructions)				646,840

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150175		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/26/2014 9:59 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,196,867	6,564,539	0.182323	646,840	117,934	90.00
91.00	Nursing School cost	0	6,564,539	0.000000	646,840	0	91.00
92.00	Allied health cost	0	6,564,539	0.000000	646,840	0	92.00
93.00	All other Medical Education	0	6,564,539	0.000000	646,840	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/26/2014 9:59 am	
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		5,750,145		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.157941	6,088,393	961,607	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.079779	1,019,095	81,302	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.121065	8,538,737	1,033,742	59.00
60.00	06000 LABORATORY	0.219028	4,569,659	1,000,883	60.00
64.00	06400 INTRAVENOUS THERAPY	0.460111	80,193	36,898	64.00
65.00	06500 RESPIRATORY THERAPY	0.301604	786,255	237,138	65.00
66.00	06600 PHYSICAL THERAPY	0.074318	686,666	51,032	66.00
69.00	06900 ELECTROCARDIOLOGY	0.107419	1,047,589	112,531	69.00
69.01	06902 CARDIAC REHAB	0.509746	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.312753	4,755,000	1,487,141	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.604745	3,336,482	2,017,721	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.264762	4,475,214	1,184,867	73.00
74.00	07400 RENAL DIALYSIS	0.181526	161,399	29,298	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.741031	124,407	92,189	92.00
200.00	Total (sum of lines 50-94 and 96-98)		35,669,089	8,326,349	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		35,669,089		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/26/2014 9:59 am
------------------------------------------------	--	----------------------	---------------------------------------------	-----------------------------------------------------------

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		418,044		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.157941	460,805	72,780	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.079779	52,756	4,209	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.121065	375,020	45,402	59.00
60.00	06000 LABORATORY	0.219028	288,736	63,241	60.00
64.00	06400 INTRAVENOUS THERAPY	0.460111	12,357	5,686	64.00
65.00	06500 RESPIRATORY THERAPY	0.301604	94,680	28,556	65.00
66.00	06600 PHYSICAL THERAPY	0.074318	23,022	1,711	66.00
69.00	06900 ELECTROCARDIOLOGY	0.107419	58,607	6,296	69.00
69.01	06902 CARDIAC REHAB	0.509746	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.312753	206,736	64,657	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.604745	107,224	64,843	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.264762	335,366	88,792	73.00
74.00	07400 RENAL DIALYSIS	0.181526	0	0	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.741031	1,948	1,444	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,017,257	447,617	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		2,017,257		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Date/Time Prepared: 2/26/2014 9:59 am	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
1.00	DRG Amounts Other than Outlier Payments		9,401,458		1.00
2.00	Outlier payments for discharges. (see instructions)		227,013		2.00
2.01	Outlier reconciliation amount		0		2.01
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		22.23		4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment. (see instructions)		0.000000		27.00
28.00	IME Adjustment (see instructions)		0		28.00
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00		30.00
31.00	Percentage of Medicaid patient days (see instructions)		0.00		31.00
32.00	Sum of lines 30 and 31		0.00		32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00		33.00
34.00	Disproportionate share adjustment (see instructions)		0		34.00
Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Date/Time Prepared: 2/26/2014 9:59 am	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 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)		0		46.00
47.00	Subtotal (see instructions)		9,628,471		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)		9,628,471		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		797,360		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 teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		10,425,831		59.00
60.00	Primary payer payments		1,320		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		10,424,511		61.00
62.00	Deductibles billed to program beneficiaries		675,035		62.00
63.00	Coinurance billed to program beneficiaries		4,736		63.00
64.00	Allowable bad debts (see instructions)		15,920		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		10,348		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,583		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		9,755,088		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		12,565		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-6,581		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low Volume Payment-1 (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low Volume Payment-2 (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,761,072		71.00
71.01	Sequestration adjustment (see instructions)		97,611		71.01
72.00	Interim payments		9,653,393		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		10,068		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 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		0.00		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Date/Time Prepared: 2/26/2014 9:59 am	
		Title XVIII	Hospital	PPS	
			before 1/1	on/after 1/1	
		0	1.00	1.01	
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/26/2014 9:59 am

		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		
		0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00	9,401,458	0	0	9,401,458	1.00	
2.00	Outlier payments for discharges (see instructions)	2.00	227,013	0	0	227,013	2.00	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	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	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	8.00	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00	
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00	
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	9,628,471	0	0	9,628,471	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	14.00	
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	9,628,471	0	0	9,628,471	15.00	
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	797,360	0	0	797,360	16.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00	
19.00	SUBTOTAL			0	0	10,425,831	19.00	
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	736,782	0	0	736,782	20.00	
21.00	Capital DRG outlier payments	2.00	60,578	0	0	60,578	21.00	
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	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	24.00	
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	797,360	0	0	797,360	26.00	
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00		
27.00	Low volume adjustment factor				0.000000	0.095714	27.00	
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			0		28.00	
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				997,898	29.00	
100.00	Transfer low volume adjustments to W/S E Part A.		Y				100.00	

LOW VOLUME CALCULATION EXHIBIT 4		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/26/2014 9:59 am
		Title XVII	Hospital	PPS
		Total (Col 2 through 4) 5.00		
1.00	DRG amounts other than outlier payments	9,401,458		1.00
2.00	Outlier payments for discharges (see instructions)	227,013		2.00
3.00	Operating outlier reconciliation	0		3.00
4.00	Managed care simulated payments	0		4.00
Indirect Medical Education Adjustment				
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)			5.00
6.00	IME payment adjustment (see instructions)	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)			7.00
8.00	IME adjustment (see instructions)	0		8.00
9.00	Total IME payment (sum of lines 6 and 8)	0		9.00
Disproportionate Share Adjustment				
10.00	Allowable disproportionate share percentage (see instructions)			10.00
11.00	Disproportionate share adjustment (see instructions)	0		11.00
Additional payment for high percentage of ESRD beneficiary discharges				
12.00	Total ESRD additional payment (see instructions)	0		12.00
13.00	Subtotal (see instructions)	9,628,471		13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	9,628,471		15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	797,360		16.00
17.00	Special add-on payments for new technologies	0		17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	0		18.00
19.00	SUBTOTAL	10,425,831		19.00
		5.00		
20.00	Capital DRG other than outlier	736,782		20.00
21.00	Capital DRG outlier payments	60,578		21.00
22.00	Indirect medical education percentage (see instructions)			22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	0		23.00
24.00	Allowable disproportionate share percentage (see instructions)			24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	0		25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	797,360		26.00
		5.00		
27.00	Low volume adjustment factor			27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	0		28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	997,898		29.00
100.00	Transfer low volume adjustments to W/S E Part A.			100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part B Date/Time Prepared: 2/26/2014 9:59 am
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,439	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,465,397	0 2.00
3.00	PPS payments		7,051,127	0 3.00
4.00	Outlier payment (see instructions)		160,925	0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	0.000 5.00
6.00	Line 2 times line 5		0	0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	0.00 7.00
8.00	Transitional corridor payment (see instructions)		0	0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	0 9.00
10.00	Organ acquisitions		0	0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		8,439	0 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		36,774	0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		36,774	0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)		0	0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	0 17.00
18.00	Total customary charges (see instructions)		36,774	0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		28,335	0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		8,439	0 21.00
22.00	Interns and residents (see instructions)		0	0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		7,212,052	0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		887,138	0 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)		6,333,353	0 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	0 29.00
30.00	Subtotal (sum of lines 27 through 29)		6,333,353	0 30.00
31.00	Primary payer payments		330	0 31.00
32.00	Subtotal (line 30 minus line 31)		6,333,023	0 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	0 33.00
34.00	Allowable bad debts (see instructions)		70,555	0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)		45,861	0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		51,544	0 36.00
37.00	Subtotal (see instructions)		6,378,884	0 37.00
38.00	MSP-LCC reconciliation amount from PS&R		-6	0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	0 39.99
40.00	Subtotal (see instructions)		6,378,890	0 40.00
40.01	Sequestration adjustment (see instructions)		63,789	0 40.01
41.00	Interim payments		6,258,839	0 41.00
42.00	Tentative settlement (for contractors use only)		0	0 42.00
43.00	Balance due provider/program (see instructions)		56,262	0 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	0 91.00
92.00	The rate used to calculate the Time Value of Money		0.00	0 92.00
93.00	Time Value of Money (see instructions)		0	0 93.00
94.00	Total (sum of lines 91 and 93)		0	0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
2/26/2014 9:59 am

		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		9,653,393		6,258,839	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)		9,653,393		6,258,839	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		10,068		56,262	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		9,663,461		6,315,101	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: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet E-1 Part II Date/Time Prepared: 2/26/2014 9:59 am
		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			1,574 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			3,410 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			692 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			5,910 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			146,599,715 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			2,938,177 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)			738,299 8.00
9.00	Sequestration adjustment amount (see instructions)			14,766 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			723,533 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			711,912 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)			11,621 32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet G Date/Time Prepared: 2/26/2014 9:59 am		
		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	2,710,952	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	15,075,154	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,349,732	0	0	0	6.00
7.00	Inventory	867,695	0	0	0	7.00
8.00	Prepaid expenses	68,620	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,372,689	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	7,963,538	0	0	0	23.00
24.00	Accumulated depreciation	-3,391,399	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)	4,572,139	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	6,658,815	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,658,815	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	21,603,643	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,750,842	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	229,921	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,182,194	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,162,957	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	861,911	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	861,911	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,024,868	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	14,578,775				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	14,578,775	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	21,603,643	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet G-1

Date/Time Prepared:
2/26/2014 9:59 am

		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		13,931,960		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		11,577,981			2.00
3.00	Total (sum of line 1 and line 2)		25,509,941		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00	ROUNDING	1		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		1		0	10.00
11.00	Subtotal (line 3 plus line 10)		25,509,942		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	DISTRIBUTIONS TO MEMEBERS	10,931,167		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		10,931,167		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		14,578,775		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	ROUNDING		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	DISTRIBUTIONS TO MEMEBERS		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/26/2014 9:59 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	11,199,921		11,199,921	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)	11,199,921		11,199,921	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,199,921		11,199,921	17.00
18.00	Ancillary services	69,859,410	54,026,529	123,885,939	18.00
19.00	Outpatient services	0	691,757	691,757	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	81,059,331	54,718,286	135,777,617	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		40,154,299		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00	GROSS UP CREDITS FOR SERVICES TO DH	2,290,206			38.00
39.00	ROUNDING	1			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		2,290,207		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		37,864,092		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150175

Period:
From 10/01/2012
To 09/30/2013

Worksheet G-3

Date/Time Prepared:
2/26/2014 9:59 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	135,777,617	1.00
2.00	Less contractual allowances and discounts on patients' accounts	87,399,253	2.00
3.00	Net patient revenues (line 1 minus line 2)	48,378,364	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	37,864,092	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,514,272	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	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	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,063,709	24.00
25.00	Total other income (sum of lines 6-24)	1,063,709	25.00
26.00	Total (line 5 plus line 25)	11,577,981	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	11,577,981	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150175	Period: From 10/01/2012 To 09/30/2013	Worksheet L Parts I-III Date/Time Prepared: 2/26/2014 9:59 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		736,782	1.00
2.00	Capital DRG outlier payments		60,578	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		16.37	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		797,360	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