

**St. Mary's Warrick Hospital**

**Provider Nos. 15-1325, 15-M325, 15-Z325  
and Aim No. 100270700**

**Hospital Statements of Reimbursable Costs  
(Medicare and Medicaid Programs)**

**June 30, 2013**

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

FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet S Parts I-III Date/Time Prepared: 11/19/2013 2:29 pm
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**PART I - COST REPORT STATUS**

Provider use only 1.  Electronically filed cost report Date: 11/19/2013 Time: 2:29 pm  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

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

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

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

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARY'S WARRICK HOSPITAL, INC. ( 151325 ) for the cost reporting period beginning 07/01/2012 and ending 06/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

**Encryption Information**

ECR: Date: 11/19/2013 Time: 2:29 pm  
FNFnEIWYgNfs9so:8bm2uOKKrw49R0  
f8SpCOaec3p1Nog9UsNkonMBDKuxyP  
8Y4y03AGw30UcLly  
PI: Date: 11/19/2013 Time: 2:29 pm  
l7tUVluToyrgzAMNYDCnd:h1z2p6o0  
2TTIrODAXqH6rIvu1:ezthXE0YuydJ  
c.1I0qudmU0SoHyx

(Signed)

Officer or Administrator of Provider(s)

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00	Hospital	0	44,236	61,998	0	0 1.00
2.00	Subprovider - IPF	0	74	0	0	0 2.00
3.00	Subprovider - IRF	0	0	0	0	0 3.00
4.00	SUBPROVIDER I	0	0	0	0	0 4.00
5.00	Swing bed - SNF	0	16,110	0	0	0 5.00
6.00	Swing bed - NF	0	0	0	0	0 6.00
200.00	Total	0	60,420	61,998	0	0 200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/19/2013 1:56 pm
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	1.00	2.00	3.00	4.00	
<b>Hospital and Hospital Health Care Complex Address:</b>					
1.00	Street: 1116 MILLIS AVE		PO Box:		1.00
2.00	City: BOONEVILLE		State: IN	Zip Code: 47601	County: WARRICK

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

<b>Hospital and Hospital-Based Component Identification:</b>										
3.00	Hospital	ST. MARY'S WARRICK HOSPITAL, INC.	151325	21780	1	03/01/2005	N	O	O	3.00
4.00	Subprovider - IPF	SERENITY PSYCH UNIT	15M325	21780	4	03/01/2005	N	P	O	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. MARY'S WARRICK - SWING BED	15Z325	21780		03/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00	0	0	0	0	0	0	24.00
25.00	0	0	0	0	0	0	25.00

	Urban/Rural S	Date of Geogr	
	1.00	2.00	
26.00	1		26.00
27.00	1		27.00
35.00	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/19/2013 1:56 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.		0			37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
		1.00				
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
<b>Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</b>						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 64.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
				1.00	2.00	3.00
<b>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</b>						
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
<b>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</b>						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 66.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151325		Period: From 07/01/2012 To 06/30/2013		Worksheet 5-2 Part I Date/Time Prepared: 11/19/2013 1:56 pm			
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))				
	1.00	2.00	3.00	4.00	5.00				
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00			
							1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>									
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y		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)				N	N 0	71.00		
<b>Inpatient Rehabilitation Facility PPS</b>									
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00		
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				N	N 0	76.00		
							1.00		
<b>Long Term Care Hospital PPS</b>									
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00		
<b>TEFRA Providers</b>									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00		
							V	XIX	
							1.00	2.00	
<b>Title V and XIX Services</b>									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.				N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.				N	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		
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		
<b>Rural Providers</b>									
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?				Y		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				N		106.00		

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			V 1.00	XIX 2.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(C). Enter "Y" for yes or "N" for no.		N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 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.	Y	N	N	N	109.00
				1.00	2.00	3.00
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	7,138		0		0118.01
			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.		N			121.00
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
<b>All Providers</b>						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	158056		140.00

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1.00		2.00		3.00			
<b>If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.</b>							
141.00	Name: ST. MARY'S HEALTH	Contractor's Name: WPS		Contractor's Number: 08101			
142.00	Street: 3700 WASHINGTON AVE.	PO Box:					
143.00	City: EVANSVILLE	State: IN	Zip Code: 47550				
				1.00			
144.00	Are provider based physicians' costs included in worksheet A?				Y	144.00	
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.				N	145.00	
				1.00	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
<b>Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)</b>							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					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			
<b>Multicampus</b>							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
				1.00			
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				N	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0.00	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00	
				Beginning	Ending		
				1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: I51325	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/19/2013 1:56 pm	
			Y/N 1.00	Date 2.00	
<b>General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.</b>					
<b>COMPLETED BY ALL HOSPITALS</b>					
<b>Provider Organization and Operation</b>					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N 1.00	Date 2.00	V/I 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 1.00	Type 2.00	Date 3.00	
<b>Financial Data and Reports</b>					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
		Y/N 1.00	Legal Oper. 2.00		
<b>Approved Educational Activities</b>					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
			Y/N 1.00		
<b>Bad Debts</b>					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
<b>Bed Complement</b>					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Description 0	Part A Y/N 1.00	Date 2.00	Part B Y/N 3.00
<b>PS&amp;R Data</b>					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		Y	10/02/2013	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/19/2013 1:56 pm		
	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.	0	1.00	2.00	3.00	21.00
			N		N	
					1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>						
<b>Capital Related Cost</b>						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
<b>Interest Expense</b>						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
<b>Purchased Services</b>						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
<b>Provider-Based Physicians</b>						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
			Y/N	Date		
			1.00	2.00		
<b>Home Office Costs</b>						
36.00	Were home office costs claimed on the cost report?				Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				N	40.00
			1.00	2.00		
<b>Cost Report Preparer Contact Information</b>						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	NANCY			GAYLE	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3236			NKGAYLE@STVINCENT.ORG	43.00

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

Provider CCN: 151325

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

Worksheet S-2  
Part IX  
Date/Time Prepared:  
11/19/2013 1:56 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151325

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/19/2013 1:56 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	45,384.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	45,384.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	45,384.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	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)		35				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet S-3 Part I Date/Time Prepared: 11/19/2013 1:56 pm
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Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,118	133	1,887			1.00
2.00 HMO and other (see instructions)	276	46				2.00
3.00 HMO IPF Subprovider	296	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	796	0	796			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	377			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,914	133	3,060			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	1,914	133	3,060	0.00	99.04	14.00
15.00 CAH visits	7,012	4,313	21,526			15.00
16.00 SUBPROVIDER - IPF	2,916	0	3,217	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	19.58	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	118.62	27.00
28.00 Observation Bed Days		0	546			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			4			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

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	287	43	528	1.00	
2.00 HMO and other (see instructions)			62			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	287	43	528	14.00	
15.00 CAH visits						15.00	
16.00 SUBPROVIDER - IPF	0.00	0	209	0	245	16.00	
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00	
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00	
19.00 SKILLED NURSING FACILITY						19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY						22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPICE						24.00	
24.10 HOSPICE (non-distinct part)						24.10	
25.00 CMHC - CMHC						25.00	
26.00 RURAL HEALTH CLINIC						26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25	
27.00 Total (sum of lines 14-26)	0.00					27.00	
28.00 Observation Bed Days						28.00	
29.00 Ambulance Trips						29.00	
30.00 Employee discount days (see instruction)						30.00	
31.00 Employee discount days - IRF						31.00	
32.00 Labor & delivery days (see instructions)						32.00	
33.00 LTCH non-covered days						33.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet S-10 Date/Time Prepared: 11/19/2013 1:56 pm
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			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.429323	1.00
<b>Medicaid (see instructions for each line)</b>				
2.00	Net revenue from Medicaid		843,351	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		6,194,946	6.00
7.00	Medicaid cost (line 1 times line 6)		2,659,633	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)		1,816,282	8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
<b>Other state or local government indigent care program (see instructions for each line)</b>				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
<b>Uncompensated care (see instructions for each line)</b>				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		12,249	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,816,282	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	878,786	244,554	1,123,340
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	377,283	104,993	482,276
22.00	Partial payment by patients approved for charity care	9,603	6,155	15,758
23.00	Cost of charity care (line 21 minus line 22)	367,680	98,838	466,518
				1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,938,644	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		300,389	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)		4,638,255	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,991,310	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,457,828	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,274,110	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151325

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

Worksheet A

Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT		746,781	746,781	0	746,781	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		229,224	229,224	0	229,224	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	31,594	1,335,524	1,367,118	0	1,367,118	4.00
5.01	00510	NONPATIENT TELEPHONES	299	12,931	13,230	0	13,230	5.01
5.02	00530	PURCHASING RECEIVING AND STORES	53,544	61,524	115,068	0	115,068	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	381,493	379,860	761,353	0	761,353	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	987,494	2,088,579	3,076,073	-127,579	2,948,494	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	170,901	487,614	658,515	0	658,515	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	45,394	45,394	0	45,394	8.00
9.00	00900	HOUSEKEEPING	0	252,740	252,740	0	252,740	9.00
10.00	01000	DIETARY	0	360,967	360,967	-52,033	308,934	10.00
11.00	01100	CAFETERIA	0	0	0	52,033	52,033	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	127,579	127,579	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	21,340	207,641	228,981	0	228,981	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	58,174	59,428	117,602	0	117,602	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	973,288	102,044	1,075,332	0	1,075,332	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	803,524	519,138	1,322,662	0	1,322,662	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	188,619	297,321	485,940	0	485,940	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	246,613	246,613	0	246,613	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	379,727	687,161	1,066,888	0	1,066,888	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	475,321	410,117	885,438	0	885,438	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	108,438	5,388	113,826	0	113,826	65.00
66.00	06600	PHYSICAL THERAPY	237,237	36,940	274,177	0	274,177	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	634	35,120	35,754	8,216	43,970	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	85,341	85,341	27,394	112,735	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,394	27,394	-27,394	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	259,677	259,677	0	259,677	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,306,088	644,500	1,950,588	0	1,950,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,177,715	9,624,961	15,802,676	8,216	15,810,892	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	36,820	20,073	56,893	-8,216	48,677	194.00
194.01	07951	OTHER NRCC - JAIL	76,453	25,432	101,885	0	101,885	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	131	131	0	131	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	6,290,988	9,670,597	15,961,585	0	15,961,585	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet A Date/Time Prepared: 11/19/2013 1:56 pm
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Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	46,864	793,645	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-62,895	166,329	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	147,322	1,514,440	4.00
5.01	00510	NONPATIENT TELEPHONES	-550	12,680	5.01
5.02	00530	PURCHASING RECEIVING AND STORES	0	115,068	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	-93,636	667,717	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	250,686	3,199,180	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-2,449	656,066	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	45,394	8.00
9.00	00900	HOUSEKEEPING	-7,370	245,370	9.00
10.00	01000	DIETARY	-39,805	269,129	10.00
11.00	01100	CAFETERIA	0	52,033	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	127,579	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	228,981	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	117,602	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-204	1,075,128	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	-3,404	1,319,258	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-227,603	258,337	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-242,295	4,318	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-237,789	829,099	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-619	884,819	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-138	113,688	65.00
66.00	06600	PHYSICAL THERAPY	-22,106	252,071	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-22,178	21,792	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	112,735	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	259,677	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-416,897	1,533,691	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-935,066	14,875,826	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	-170	48,507	194.00
194.01	07951	OTHER NRCC - JAIL	0	101,885	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	131	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-935,236	15,026,349	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - NURSING ADMIN SALARIES</b>					
1.00	NURSING ADMINISTRATION	13.00	127,579	0	1.00
	TOTALS		127,579	0	
<b>B - CAFETERIA EXPENSE</b>					
1.00	CAFETERIA	11.00	0	52,033	1.00
	TOTALS		0	52,033	
<b>C - EKG EXPENSE</b>					
1.00	ELECTROCARDIOLOGY	69.00	0	8,216	1.00
	TOTALS		0	8,216	
<b>D - IMPLANTABLE EXPENSE</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	27,394	1.00
	TOTALS		0	27,394	
500.00	Grand Total: Increases		127,579	87,643	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - NURSING ADMIN SALARIES</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	127,579	0	0		1.00
	TOTALS		127,579	0			
<b>B - CAFETERIA EXPENSE</b>							
1.00	DIETARY	10.00	0	52,033	0		1.00
	TOTALS		0	52,033			
<b>C - EKG EXPENSE</b>							
1.00	OTHER NRCC - PHYSICIAN CLINIC	194.00	0	8,216	0		1.00
	TOTALS		0	8,216			
<b>D - IMPLANTABLE EXPENSE</b>							
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	27,394	0		1.00
	TOTALS		0	27,394			
500.00	Grand Total: Decreases		127,579	87,643			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151325

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/19/2013 1:56 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	486,146	0	0	0	40,904 1.00
2.00	Land Improvements	0	0	0	0	0 2.00
3.00	Buildings and Fixtures	11,715,449	121,487	0	121,487	0 3.00
4.00	Building Improvements	0	0	0	0	0 4.00
5.00	Fixed Equipment	0	0	0	0	0 5.00
6.00	Movable Equipment	8,872,051	0	0	0	1,081,656 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	21,073,646	121,487	0	121,487	1,122,560 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	21,073,646	121,487	0	121,487	1,122,560 10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	445,242	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	11,836,936	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	7,790,395	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	20,072,573	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	20,072,573	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151325

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	CAP REL COSTS-BLDG & FIXT	746,781	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	98,954	128,699	1,571	0	2.00
3.00	Total (sum of lines 1-2)	746,781	98,954	128,699	1,571	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	746,781				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	229,224				2.00
3.00	Total (sum of lines 1-2)	0	976,005				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151325

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	11,593,962	0	11,593,962	0.598109	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,790,395	0	7,790,395	0.401891	0	2.00
3.00	Total (sum of lines 1-2)	19,384,357	0	19,384,357	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	793,645	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	98,954	2.00
3.00	Total (sum of lines 1-2)	0	0	0	793,645	98,954	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	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	793,645	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	65,804	1,571	0	0	166,329	2.00
3.00	Total (sum of lines 1-2)	65,804	1,571	0	0	959,974	3.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.
				Cost Center	Line #		
				1.00	2.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT		1.00	0 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 2.00
3.00	Investment income - other (chapter 2)	B	-30,006	OTHER ADMINISTRATIVE AND GENERAL		5.04	0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0			0.00	0 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0			0.00	0 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0			0.00	0 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0			0.00	0 7.00
8.00	Television and radio service (chapter 21)		0			0.00	0 8.00
9.00	Parking lot (chapter 21)		0			0.00	0 9.00
10.00	Provider-based physician adjustment	A-8-2	-1,141,659				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	1,578,030				0 12.00
13.00	Laundry and linen service		0			0.00	0 13.00
14.00	Cafeteria-employees and guests	B	-37,116	DIETARY		10.00	0 14.00
15.00	Rental of quarters to employee and others		0			0.00	0 15.00
16.00	Sale of medical and surgical supplies to other than patients		0			0.00	0 16.00
17.00	Sale of drugs to other than patients		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	B	-2,689	DIETARY		10.00	0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00	0 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00	0 24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00	0 25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00	0 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00	0 28.00
29.00	Physicians' assistant		0			0.00	0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00	0 30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00	0 30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00	0 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00	OTHER EXERCISE REVENUE	B	-22,048	PHYSICAL THERAPY		66.00	0 33.00
33.01	OTHER HOUSEKEEPING REVENUE	B	-7,370	HOUSEKEEPING		9.00	0 33.01

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		Wkst. A-7	Ref.
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	
33.02 OTHER MAINTENANCE REVENUE	B	-2,011	OPERATION OF PLANT	7.00	0	33.02
33.03 INCOME GENESIS	B	-1,436	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.03
33.04 PENSION ADJUSTMENT	A	147,325	EMPLOYEE BENEFITS	4.00	0	33.04
33.05 OTHER ADMIN REVENUE	B	-12,602	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.05
33.06 OTHER PLANT OPS REVENUE	B	-343	OPERATION OF PLANT	7.00	0	33.06
33.07		0		0.00	0	33.07
33.08		0		0.00	0	33.08
33.09 PHYSICIAN BILLING COSTS	A	-93,636	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	33.09
33.10		0		0.00	0	33.10
33.11 UNNECESSARY BORROWING	A	-62,895	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.11
33.12 TELEPHONE OPERATOR SALARY	A	-12	NONPATIENT TELEPHONES	5.01	0	33.12
33.13 TELEPHONE SERVICES	A	-538	NONPATIENT TELEPHONES	5.01	0	33.13
33.14 TELEPHONE OPERATOR BENEFITS	A	-3	EMPLOYEE BENEFITS	4.00	0	33.14
33.15 NON-ALLOWABLE COMMUNITY PROJECTS	A	-3,664	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.15
33.16		0		0.00	0	33.16
33.17 SMMC RELATED PARTY INTEREST	A	-41,118	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.17
33.18 AHA LOBBYING	A	-489	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.18
33.19 NON-ALLOWABLE CED SALARIES	A	-3,374	SUBPROVIDER - IPF	40.00	0	33.19
33.20		0		0.00	0	33.20
33.21 PROVIDER TAX ADJUSTMENT	A	-1,197,582	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.21
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-935,236				50.00

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

Provider CCN: 151325

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

Worksheet A-8-1

Date/Time Prepared: 11/19/2013 1:56 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	SMHS HO DIRECT COSTS	2,134,583	0 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	SMHS HO POOLED COSTS	37,511	0 2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION BOND AMORTIZATION	75,157	65,804 3.00
4.00	0.00			0	0 4.00
4.01	5.04	OTHER ADMINISTRATIVE AND GENERAL	MISSION HEALTH FEE	0	597,000 4.01
4.02	0.00			0	0 4.02
4.03	0.00			0	0 4.03
4.04	0.00			0	0 4.04
4.05	0.00			0	0 4.05
4.06	4.00	EMPLOYEE BENEFITS	BENEFITS PASS THROUGH	2,841	2,841 4.06
4.07	5.01	NONPATIENT TELEPHONES	PHONES PASS THROUGH	11,954	11,954 4.07
4.08	8.00	LAUNDRY & LINEN SERVICE	LINENS PASS THROUGH	49,748	49,748 4.08
4.09	7.00	OPERATION OF PLANT	OPERATIONS PASS THROUGH	2,334	2,334 4.09
4.10	15.00	PHARMACY	PHARMACY PASS THROUGH	17,415	17,415 4.10
4.11	5.04	OTHER ADMINISTRATIVE AND GENERAL	A&G PASS THROUGH	916,721	916,721 4.11
4.12	60.00	LABORATORY	LAB PASS THROUGH	391	391 4.12
4.13	50.00	OPERATING ROOM	OR PASS THROUGH	1,025	1,025 4.13
4.14	7.00	OPERATION OF PLANT	TRIMEDX	4,054	4,149 4.14
4.15	30.00	ADULTS & PEDIATRICS	TRIMEDX	8,663	8,867 4.15
4.16	40.00	SUBPROVIDER - IPF	TRIMEDX	1,257	1,287 4.16
4.17	50.00	OPERATING ROOM	TRIMEDX	43,413	44,437 4.17
4.18	53.00	ANESTHESIOLOGY	TRIMEDX	4,031	4,126 4.18
4.19	54.00	RADIOLOGY-DIAGNOSTIC	TRIMEDX	171,192	175,226 4.19
4.20	60.00	LABORATORY	TRIMEDX	26,247	26,866 4.20
4.21	65.00	RESPIRATORY THERAPY	TRIMEDX	547	560 4.21
4.22	66.00	PHYSICAL THERAPY	TRIMEDX	2,479	2,537 4.22
4.23	91.00	EMERGENCY	TRIMEDX	3,213	3,288 4.23
4.24	194.00	OTHER NRCC - PHYSICIAN CLINIC	TRIMEDX	7,218	7,388 4.24
5.00	0			3,521,994	1,943,964 5.00

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

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

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

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

6.00	B	0.00	ST. MARY'S HEAL	100.00	6.00
7.00	B	0.00	ASCENSION	100.00	7.00
8.00	A	0.00	TRIMEDX	0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. other (financial or non-financial) specify:				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: 151325

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

worksheet A-8-1

Date/Time Prepared:  
11/19/2013 1:56 pm

	Net Adjustments (col. 4 minus col. 5)*	wkst. A-7 Ref.	
	6.00	7.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>			
1.00	2,134,583	0	1.00
2.00	37,511	9	2.00
3.00	9,353	9	3.00
4.00	0	0	4.00
4.01	-597,000	0	4.01
4.02	0	0	4.02
4.03	0	0	4.03
4.04	0	0	4.04
4.05	0	0	4.05
4.06	0	0	4.06
4.07	0	0	4.07
4.08	0	0	4.08
4.09	0	0	4.09
4.10	0	0	4.10
4.11	0	0	4.11
4.12	0	0	4.12
4.13	0	0	4.13
4.14	-95	0	4.14
4.15	-204	0	4.15
4.16	-30	0	4.16
4.17	-1,024	0	4.17
4.18	-95	0	4.18
4.19	-4,034	0	4.19
4.20	-619	0	4.20
4.21	-13	0	4.21
4.22	-58	0	4.22
4.23	-75	0	4.23
4.24	-170	0	4.24
5.00	1,578,030		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	HOME OFFICE	6.00
7.00	ADMINISTRATION	7.00
8.00	TECHNOLOGY MGMT	8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151325

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

Worksheet A-8-2

Date/Time Prepared:  
11/19/2013 1:56 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,344,586	416,822	927,764	0	0	1.00
2.00	50.00	OPERATING ROOM	226,579	226,579	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	242,200	242,200	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	233,755	233,755	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	125	125	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	22,178	22,178	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			2,069,423	1,141,659	927,764			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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	416,822		1.00
2.00	50.00	OPERATING ROOM	0	0	0	226,579		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	242,200		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	233,755		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	125		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	22,178		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,141,659		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151325		Period: From 07/01/2012 To 06/30/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/19/2013 1:56 pm	
		Physical Therapy				Cost	
						1.00	
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)					26	1.00
2.00	Line 1 multiplied by 15 hours per week					390	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.21	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	208.00	496.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	93.65	74.92	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.46	37.46	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					19,479	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					37,160	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					56,639	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					56,639	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					56,639	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
<b>Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.</b>							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/19/2013 1:56 pm
		Physical Therapy	Cost

46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						1.00	0	46.00
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			

**PART V - OVERTIME COMPUTATION**

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00			48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00			49.00
<b>CALCULATION OF LIMIT</b>									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		0.00	51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>									
52.00	Adjusted hourly salary equivalency amount (see instructions)	74.92	0.00	0.00	0.00	0.00			52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0			53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0			54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0			55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		0	56.00
								1.00	

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

57.00	Salary equivalency amount (from line 23)							56,639	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)							0	59.00
60.00	Overtime allowance (from column 5, line 56)							0	60.00
61.00	Equipment cost (see instructions)							0	61.00
62.00	Supplies (see instructions)							0	62.00
63.00	Total allowance (sum of lines 57-62)							56,639	63.00
64.00	Total cost of outside supplier services (from your records)							30,025	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							0	65.00
<b>LINE 33 CALCULATION</b>									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							0	100.02
<b>LINE 34 CALCULATION</b>									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	101.01
101.02	Line 34 = sum of lines 27 and 31							0	101.02
<b>LINE 35 CALCULATION</b>									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0	102.01
102.02	Line 35 = sum of lines 31 and 32							0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	793,645	793,645			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	166,329		166,329		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,514,440	7,503	1,572	1,523,515	4.00
5.01 00510	NONPATIENT TELEPHONES	12,680	3,415	716	74	16,885 5.01
5.02 00530	PURCHASING RECEIVING AND STORES	115,068	14,102	2,955	13,194	0 5.02
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE	667,717	25,219	5,285	94,002	1,837 5.03
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL	3,199,180	101,728	21,321	211,888	3,321 5.04
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	656,066	57,721	12,097	42,111	706 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	45,394	5,906	1,238	0	141 8.00
9.00 00900	HOUSEKEEPING	245,370	14,365	3,010	0	71 9.00
10.00 01000	DIETARY	269,129	33,531	7,027	0	283 10.00
11.00 01100	CAFETERIA	52,033	12,200	2,557	0	71 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	127,579	2,795	586	31,436	141 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	9,090	1,905	0	71 14.00
15.00 01500	PHARMACY	228,981	12,841	2,691	5,258	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	117,602	19,051	3,993	14,334	1,201 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,075,128	99,564	20,866	239,824	989 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
40.00 04000	SUBPROVIDER - IPF	1,319,258	70,898	14,859	197,993	777 40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	258,337	61,725	12,936	46,477	989 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	4,318	946	198	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	829,099	48,085	10,077	93,567	1,130 54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	884,819	22,887	4,796	117,122	706 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	113,688	6,746	1,414	26,720	424 65.00
66.00 06600	PHYSICAL THERAPY	252,071	48,463	10,157	58,457	636 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	21,792	2,196	460	156	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	112,735	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	259,677	0	0	0	353 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	1,533,691	37,241	7,805	321,829	636 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,875,826	718,218	150,521	1,514,442	14,483 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,539	951	0	71 190.00
194.00 07950	OTHER NRCC - PHYSICIAN CLINIC	48,507	43,262	9,067	9,073	2,331 194.00
194.01 07951	OTHER NRCC - JAIL	101,885	0	0	0	0 194.01
194.02 07952	OTHER NRCC - PUBLIC RELATIONS	131	0	0	0	0 194.02
194.03 07953	OTHER NRCC - DR. OFFICE	0	27,626	5,790	0	0 194.03
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	15,026,349	793,645	166,329	1,523,515	16,885 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
		5.02	5.03	5A.03	5.04	6.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00530	145,319					5.02
5.03	00550	2,499	796,559				5.03
5.04	00560	1,634	0	3,539,072	3,539,072		5.04
6.00	00600	0	0	0	0	0	6.00
7.00	00700	51,149	0	819,850	252,584	0	7.00
8.00	00800	1,462	0	54,141	16,680	0	8.00
9.00	00900	7,131	0	269,947	83,167	0	9.00
10.00	01000	8,843	0	318,813	98,222	0	10.00
11.00	01100	0	0	66,861	20,599	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	162,537	50,075	0	13.00
14.00	01400	0	0	11,066	3,409	0	14.00
15.00	01500	1,233	0	251,004	77,331	0	15.00
16.00	01600	0	0	156,181	48,117	0	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	17,875	58,580	1,512,826	466,081	0	30.00
31.00	03100	0	0	0	0	0	31.00
40.00	04000	11,315	96,866	1,711,966	527,433	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	6,590	18,231	405,285	124,863	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	2,244	7,706	2,374	0	53.00
54.00	05400	3,631	148,640	1,134,229	349,440	0	54.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	16,865	101,747	1,148,942	353,973	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	1,058	18,339	168,389	51,878	0	65.00
66.00	06600	1,628	39,084	410,496	126,468	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	1,477	14,239	40,320	12,422	0	69.00
71.00	07100	0	30,044	142,779	43,988	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	54,781	314,811	96,989	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	9,966	213,764	2,124,932	654,666	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		144,356	796,559	14,772,153	3,460,759	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	5,561	1,713	0	190.00
194.00	07950	957	0	113,197	34,874	0	194.00
194.01	07951	6	0	101,891	31,391	0	194.01
194.02	07952	0	0	131	40	0	194.02
194.03	07953	0	0	33,416	10,295	0	194.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		145,319	796,559	15,026,349	3,539,072	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00530	PURCHASING RECEIVING AND STORES					5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	1,072,434				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,846	81,667			8.00
9.00	00900	HOUSEKEEPING	26,381	4,729	384,224		9.00
10.00	01000	DIETARY	61,580	0	0	478,615	10.00
11.00	01100	CAFETERIA	22,405	0	1,501	0	111,366
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	5,133	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	16,693	0	0	0	0
15.00	01500	PHARMACY	23,582	0	6,738	0	2,524
16.00	01600	MEDICAL RECORDS & LIBRARY	34,987	0	3,296	0	2,849
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	182,851	27,511	122,155	331,509	29,026
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
40.00	04000	SUBPROVIDER - IPF	130,204	14,341	66,160	147,106	24,686
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	113,357	4,973	2,424	0	4,533
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	1,737	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,308	5,878	34,713	0	10,907
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	42,031	56	13,907	0	13,134
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	12,389	0	6,042	0	2,458
66.00	06600	PHYSICAL THERAPY	89,003	4,283	13,006	0	5,005
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	4,033	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	68,392	19,469	55,292	0	15,183
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	933,912	81,240	325,234	478,615	110,305
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,337	0	1,977	0	0
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	79,450	427	26,511	0	1,061
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	1,538	0	0
194.03	07953	OTHER NRCC - DR. OFFICE	50,735	0	28,964	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,072,434	81,667	384,224	478,615	111,366

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: I51325

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		12.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00530						5.02
5.03	00550						5.03
5.04	00560						5.04
6.00	00600						6.00
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
12.00	01200	0					12.00
13.00	01300	0	217,745				13.00
14.00	01400	0	0	31,168			14.00
15.00	01500	0	0	0	361,179		15.00
16.00	01600	0	0	0	0	245,430	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	59,626	0	494	18,048	30.00
31.00	03100	0	0	0	0	0	31.00
40.00	04000	0	50,714	0	0	29,843	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	9,312	0	1,188	5,617	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	932	691	53.00
54.00	05400	0	22,407	0	9,721	45,795	54.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	26,982	0	0	31,347	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	5,050	0	213	5,650	65.00
66.00	06600	0	10,283	0	107	12,042	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	4,387	69.00
71.00	07100	0	0	31,168	0	9,256	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	348,398	16,878	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	31,191	0	126	65,876	91.00
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		0	215,565	31,168	361,179	245,430	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	2,180	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		0	217,745	31,168	361,179	245,430	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet B Part I Date/Time Prepared: 11/19/2013 1:56 pm	
Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
		17.00	24.00	25.00	26.00
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00510	NONPATIENT TELEPHONES			5.01
5.02	00530	PURCHASING RECEIVING AND STORES			5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL			5.04
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
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	0		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	2,750,127	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	2,702,453	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	671,552	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	13,440	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,701,398	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	1,630,372	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	252,069	65.00
66.00	06600	PHYSICAL THERAPY	0	670,693	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	61,162	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	227,191	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	777,076	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	3,035,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	14,492,660	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,588	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	257,700	194.00
194.01	07951	OTHER NRCC - JAIL	0	133,282	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	1,709	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	123,410	194.03
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	15,026,349	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151325

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,503	1,572	9,075	9,075 4.00
5.01 00510	NONPATIENT TELEPHONES	0	3,415	716	4,131	0 5.01
5.02 00530	PURCHASING RECEIVING AND STORES	0	14,102	2,955	17,057	79 5.02
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE	0	25,219	5,285	30,504	560 5.03
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL	0	101,728	21,321	123,049	1,262 5.04
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	0	57,721	12,097	69,818	251 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	5,906	1,238	7,144	0 8.00
9.00 00900	HOUSEKEEPING	0	14,365	3,010	17,375	0 9.00
10.00 01000	DIETARY	0	33,531	7,027	40,558	0 10.00
11.00 01100	CAFETERIA	0	12,200	2,557	14,757	0 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	0	2,795	586	3,381	187 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	9,090	1,905	10,995	0 14.00
15.00 01500	PHARMACY	0	12,841	2,691	15,532	31 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	19,051	3,993	23,044	85 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	99,564	20,866	120,430	1,429 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
40.00 04000	SUBPROVIDER - IPF	0	70,898	14,859	85,757	1,180 40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	61,725	12,936	74,661	277 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	0	946	198	1,144	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	48,085	10,077	58,162	557 54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	22,887	4,796	27,683	698 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0	6,746	1,414	8,160	159 65.00
66.00 06600	PHYSICAL THERAPY	0	48,463	10,157	58,620	348 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	2,196	460	2,656	1 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	0	37,241	7,805	45,046	1,917 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	718,218	150,521	868,739	9,021 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,539	951	5,490	0 190.00
194.00 07950	OTHER NRCC - PHYSICIAN CLINIC	0	43,262	9,067	52,329	54 194.00
194.01 07951	OTHER NRCC - JAIL	0	0	0	0	0 194.01
194.02 07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0 194.02
194.03 07953	OTHER NRCC - DR. OFFICE	0	27,626	5,790	33,416	0 194.03
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	793,645	166,329	959,974	9,075 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 151325		Period: From 07/01/2012 To 06/30/2013		Worksheet B Part II Date/Time Prepared: 11/19/2013 1:56 pm	
Cost Center Description			NONPATIENT TELEPHONES	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	NONPATIENT TELEPHONES	4,131					5.01
5.02	00530	PURCHASING RECEIVING AND STORES	0	17,136				5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	449	295	31,808			5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	812	193	0	125,316		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	173	6,031	0	8,944	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35	172	0	591	0	8.00
9.00	00900	HOUSEKEEPING	17	841	0	2,945	0	9.00
10.00	01000	DIETARY	69	1,043	0	3,478	0	10.00
11.00	01100	CAFETERIA	17	0	0	729	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	35	0	0	1,773	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17	0	0	121	0	14.00
15.00	01500	PHARMACY	0	145	0	2,738	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	294	0	0	1,704	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	242	2,108	2,339	16,503	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	190	1,334	3,867	18,676	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	242	777	728	4,421	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	90	84	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	277	428	5,934	12,373	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	173	1,989	4,062	12,534	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	104	125	732	1,837	0	65.00
66.00	06600	PHYSICAL THERAPY	156	192	1,560	4,478	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	174	568	440	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,199	1,558	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	86	0	2,187	3,434	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	156	1,175	8,542	23,181	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,544	17,022	31,808	122,542	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17	0	0	61	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	570	113	0	1,235	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	1	0	1,112	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	1	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	0	365	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,131	17,136	31,808	125,316	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151325

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00530						5.02
5.03	00550						5.03
5.04	00560						5.04
6.00	00600						6.00
7.00	00700	85,217					7.00
8.00	00800	862	8,804				8.00
9.00	00900	2,096	510	23,784			9.00
10.00	01000	4,893	0	0	50,041		10.00
11.00	01100	1,780	0	93	0	17,376	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	408	0	0	0	0	13.00
14.00	01400	1,326	0	0	0	0	14.00
15.00	01500	1,874	0	417	0	394	15.00
16.00	01600	2,780	0	204	0	444	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	14,533	2,965	7,562	34,661	4,528	30.00
31.00	03100	0	0	0	0	0	31.00
40.00	04000	10,346	1,546	4,095	15,380	3,852	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	9,007	536	150	0	707	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	138	0	0	0	0	53.00
54.00	05400	7,017	634	2,149	0	1,702	54.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	3,340	6	861	0	2,049	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	984	0	374	0	384	65.00
66.00	06600	7,072	462	805	0	781	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	320	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	5,435	2,099	3,423	0	2,369	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		74,211	8,758	20,133	50,041	17,210	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	662	0	122	0	0	190.00
194.00	07950	6,313	46	1,641	0	166	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	95	0	0	194.02
194.03	07953	4,031	0	1,793	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		85,217	8,804	23,784	50,041	17,376	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet B Part II Date/Time Prepared: 11/19/2013 1:56 pm			
Cost Center Description		MAINTENANCE OF PERSONNEL 12.00	NURSING ADMINISTRATION 13.00	CENTRAL SERVICES & SUPPLY 14.00	PHARMACY 15.00	MEDICAL RECORDS & LIBRARY 16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00530	PURCHASING RECEIVING AND STORES					5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	5,784			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	12,459		14.00
15.00	01500	PHARMACY	0	0	0	21,131	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	28,555	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	1,584	0	29	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	1,347	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	247	0	70	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	55	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	595	0	569	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	717	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	134	0	12	65.00
66.00	06600	PHYSICAL THERAPY	0	273	0	6	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	12,459	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,383	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	829	0	7	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	5,726	12,459	21,131	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	58	0	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	0	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	5,784	12,459	21,131	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet B Part II Date/Time Prepared: 11/19/2013 1:56 pm
Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
	17.00	24.00	25.00	26.00
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00510	NONPATIENT TELEPHONES		5.01
5.02	00530	PURCHASING RECEIVING AND STORES		5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL		5.04
6.00	00600	MAINTENANCE & REPAIRS		6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
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	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	211,013
31.00	03100	INTENSIVE CARE UNIT	0	0
40.00	04000	SUBPROVIDER - IPF	0	151,043
41.00	04100	SUBPROVIDER - IRF	0	0
42.00	04200	SUBPROVIDER	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	92,477
51.00	05100	RECOVERY ROOM	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0
53.00	05300	ANESTHESIOLOGY	0	1,591
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	95,726
56.00	05600	RADIOISOTOPE	0	0
57.00	05700	CT SCAN	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0
60.00	06000	LABORATORY	0	57,760
60.01	06001	BLOOD LABORATORY	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0
65.00	06500	RESPIRATORY THERAPY	0	13,662
66.00	06600	PHYSICAL THERAPY	0	76,154
67.00	06700	OCCUPATIONAL THERAPY	0	0
68.00	06800	SPEECH PATHOLOGY	0	0
69.00	06900	ELECTROCARDIOLOGY	0	4,669
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,293
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,054
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0	0
91.00	09100	EMERGENCY	0	101,841
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	850,283
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,352
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	62,525
194.01	07951	OTHER NRCC - JAIL	0	1,113
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	96
194.03	07953	OTHER NRCC - DR. OFFICE	0	39,605
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	959,974

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151325

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

Worksheet B-1  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NONPATIENT TELEPHONES)	PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	75,527				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		75,527			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	714	714	6,182,941		4.00
5.01 00510	NONPATIENT TELEPHONES	325	325	299	239	5.01
5.02 00530	PURCHASING RECEIVING AND STORES	1,342	1,342	53,544	0	48,908 5.02
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE	2,400	2,400	381,493	26	841 5.03
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL	9,681	9,681	859,915	47	550 5.04
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	5,493	5,493	170,901	10	17,215 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	562	562	0	2	492 8.00
9.00 00900	HOUSEKEEPING	1,367	1,367	0	1	2,400 9.00
10.00 01000	DIETARY	3,191	3,191	0	4	2,976 10.00
11.00 01100	CAFETERIA	1,161	1,161	0	1	0 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	266	266	127,579	2	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	865	865	0	1	0 14.00
15.00 01500	PHARMACY	1,222	1,222	21,340	0	415 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,813	1,813	58,174	17	0 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	9,475	9,475	973,288	14	6,016 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
40.00 04000	SUBPROVIDER - IPF	6,747	6,747	803,524	11	3,808 40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	5,874	5,874	188,619	14	2,218 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	90	90	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,576	4,576	379,727	16	1,222 54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	2,178	2,178	475,321	10	5,676 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	642	642	108,438	6	356 65.00
66.00 06600	PHYSICAL THERAPY	4,612	4,612	237,237	9	548 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	209	209	634	0	497 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	5	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	3,544	3,544	1,306,088	9	3,354 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	68,349	68,349	6,146,121	205	48,584 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	432	432	0	1	0 190.00
194.00 07950	OTHER NRCC - PHYSICIAN CLINIC	4,117	4,117	36,820	33	322 194.00
194.01 07951	OTHER NRCC - JAIL	0	0	0	0	2 194.01
194.02 07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0 194.02
194.03 07953	OTHER NRCC - DR. OFFICE	2,629	2,629	0	0	0 194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)	793,645	166,329	1,523,515	16,885	145,319 202.00
203.00	Unit cost multiplier (wkst. B, Part I)	10.508096	2.202246	0.246406	70.648536	2.971273 203.00
204.00	Cost to be allocated (per wkst. B, Part II)			9,075	4,131	17,136 204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.001468	17.284519	0.350372 205.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151325

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

Worksheet B-1

Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (ASSIGNED TIME)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5A.04	5.04	6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00530	PURCHASING RECEIVING AND STORES					5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	33,757,018				5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	-3,539,072	11,487,277		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	819,850	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	54,141	0	8.00
9.00	00900	HOUSEKEEPING	0	0	269,947	0	9.00
10.00	01000	DIETARY	0	0	318,813	0	10.00
11.00	01100	CAFETERIA	0	0	66,861	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	162,537	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	11,066	0	14.00
15.00	01500	PHARMACY	0	0	251,004	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	156,181	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,482,518	0	1,512,826	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	4,105,004	0	1,711,966	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	772,593	0	405,285	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	95,116	0	7,706	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,299,125	0	1,134,229	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	4,311,850	0	1,148,942	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	777,169	0	168,389	0	65.00
66.00	06600	PHYSICAL THERAPY	1,656,330	0	410,496	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	603,421	0	40,320	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,273,231	0	142,779	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,321,538	0	314,811	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	9,059,123	0	2,124,932	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	33,757,018	-3,539,072	11,233,081	0	48,394
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	5,561	0	432
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	0	113,197	0	4,117
194.01	07951	OTHER NRCC - JAIL	0	0	101,891	0	0
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	131	0	0
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	33,416	0	2,629
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per wkst. B, Part I)	796,559		3,539,072	0	1,072,434
203.00		Unit cost multiplier (wkst. B, Part I)	0.023597		0.308086	0.000000	19.298100
204.00		Cost to be allocated (per wkst. B, Part II)	31,808		125,316	0	85,217
205.00		Unit cost multiplier (wkst. B, Part II)	0.000942		0.010909	0.000000	1.533452

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151325

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

Worksheet B-1

Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	
		8.00	9.00	10.00	11.00	12.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00530	PURCHASING RECEIVING AND STORES					5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,408				8.00
9.00	00900	HOUSEKEEPING	1,008	52,465			9.00
10.00	01000	DIETARY	0	0	30,375		10.00
11.00	01100	CAFETERIA	0	205	0	183,753	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00	01500	PHARMACY	0	920	0	4,165	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	450	0	4,700	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	5,864	16,680	21,039	47,891	0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
40.00	04000	SUBPROVIDER - IPF	3,057	9,034	9,336	40,732	0 40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0 42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,060	331	0	7,479	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,253	4,740	0	17,997	0 54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	12	1,899	0	21,671	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	825	0	4,056	0 65.00
66.00	06600	PHYSICAL THERAPY	913	1,776	0	8,259	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	4,150	7,550	0	25,052	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,317	44,410	30,375	182,002	0 118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	270	0	0	0 190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	91	3,620	0	1,751	0 194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0 194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	210	0	0	0 194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	3,955	0	0	0 194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per wkst. B, Part I)	81,667	384,224	478,615	111,366	0 202.00
203.00		Unit cost multiplier (wkst. B, Part I)	4.691349	7.323435	15.756872	0.606064	0.000000 203.00
204.00		Cost to be allocated (per wkst. B, Part II)	8,804	23,784	50,041	17,376	0 204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.505744	0.453331	1.647440	0.094562	0.000000 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151325

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

Worksheet B-1

Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00530						5.02
5.03	00550						5.03
5.04	00560						5.04
6.00	00600						6.00
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
12.00	01200						12.00
13.00	01300	174,888					13.00
14.00	01400	0	100				14.00
15.00	01500	0	0	242,854			15.00
16.00	01600	0	0	0	33,757,018		16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	47,891	0	332	2,482,518	0	30.00
31.00	03100	0	0	0	0	0	31.00
40.00	04000	40,732	0	0	4,105,004	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	7,479	0	799	772,593	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	627	95,116	0	53.00
54.00	05400	17,997	0	6,536	6,299,125	0	54.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	21,671	0	0	4,311,850	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	4,056	0	143	777,169	0	65.00
66.00	06600	8,259	0	72	1,656,330	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	603,421	0	69.00
71.00	07100	0	100	0	1,273,231	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	234,260	2,321,538	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	25,052	0	85	9,059,123	0	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		173,137	100	242,854	33,757,018	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	1,751	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00							201.00
202.00		217,745	31,168	361,179	245,430	0	202.00
203.00		1.245054	311.680000	1.487227	0.007270	0.000000	203.00
204.00		5,784	12,459	21,131	28,555	0	204.00
205.00		0.033073	124.590000	0.087011	0.000846	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151325

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		Total Costs
				Total Costs	RCE Disallowance	Costs		
						Total Costs	Total Costs	
1.00	2.00	3.00	4.00	5.00				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	2,750,127		2,750,127	0	2,750,127	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,702,453		2,702,453	0	2,702,453	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	671,552		671,552	0	671,552	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	13,440		13,440	0	13,440	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,701,398		1,701,398	0	1,701,398	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,630,372		1,630,372	0	1,630,372	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	252,069	0	252,069	0	252,069	65.00
66.00	06600	PHYSICAL THERAPY	670,693	0	670,693	0	670,693	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	61,162		61,162	0	61,162	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	227,191		227,191	0	227,191	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	777,076		777,076	0	777,076	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,035,127		3,035,127	0	3,035,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	456,969		456,969	0	456,969	92.00
200.00		Subtotal (see instructions)	14,949,629	0	14,949,629	0	14,949,629	200.00
201.00		Less Observation Beds	456,969		456,969	0	456,969	201.00
202.00		Total (see instructions)	14,492,660	0	14,492,660	0	14,492,660	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151325

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/19/2013 1:56 pm

		Title XVIII			Hospital	Cost		
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				
		9.00	10.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	2,110,524		2,110,524			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
40.00	04000	SUBPROVIDER - IPF	4,105,004		4,105,004			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	140,815	631,778	772,593	0.869218	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	13,114	82,002	95,116	0.141301	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,393,525	4,905,600	6,299,125	0.270101	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,148,103	3,163,747	4,311,850	0.378114	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	501,232	275,937	777,169	0.324343	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	679,048	977,282	1,656,330	0.404927	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	153,112	450,309	603,421	0.101359	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	500,487	772,744	1,273,231	0.178437	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,346,968	974,570	2,321,538	0.334725	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	3,935,462	5,123,661	9,059,123	0.335035	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	371,994	371,994	1.228431	0.000000	92.00
200.00		Subtotal (see instructions)	16,027,394	17,729,624	33,757,018			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,027,394	17,729,624	33,757,018			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet C Part I Date/Time Prepared: 11/19/2013 1:56 pm
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.869218		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.141301		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.270101		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.378114		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.324343		65.00
66.00	06600	PHYSICAL THERAPY	0.404927		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.101359		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.178437		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.334725		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.335035		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.228431		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: 151325

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Cost
				Total Costs	RCE Disallowance	Total Costs	Total Costs	
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	2,750,127		2,750,127	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,702,453		2,702,453	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	671,552		671,552	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	13,440		13,440	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,701,398		1,701,398	0	0	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,630,372		1,630,372	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	252,069	0	252,069	0	0	65.00
66.00	06600	PHYSICAL THERAPY	670,693	0	670,693	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	61,162		61,162	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	227,191		227,191	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	777,076		777,076	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,035,127		3,035,127	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	456,969		456,969	0	0	92.00
200.00		Subtotal (see instructions)	14,949,629	0	14,949,629	0	0	200.00
201.00		Less Observation Beds	456,969		456,969	0	0	201.00
202.00		Total (see instructions)	14,492,660	0	14,492,660	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151325

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		Title XIX			Hospital	Cost		
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00	9.00	10.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	2,110,524		2,110,524			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
40.00	04000	SUBPROVIDER - IPF	4,105,004		4,105,004			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	140,815	631,778	772,593	0.869218	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	13,114	82,002	95,116	0.141301	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,393,525	4,905,600	6,299,125	0.270101	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,148,103	3,163,747	4,311,850	0.378114	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	501,232	275,937	777,169	0.324343	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	679,048	977,282	1,656,330	0.404927	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	153,112	450,309	603,421	0.101359	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	500,487	772,744	1,273,231	0.178437	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,346,968	974,570	2,321,538	0.334725	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	3,935,462	5,123,661	9,059,123	0.335035	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	371,994	371,994	1.228431	0.000000	92.00
200.00		Subtotal (see instructions)	16,027,394	17,729,624	33,757,018			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,027,394	17,729,624	33,757,018			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151325

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 151325

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

Worksheet C  
Part II  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		Title XIX			Hospital		Cost	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	671,552	92,477	579,075	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	13,440	1,591	11,849	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,701,398	95,726	1,605,672	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,630,372	57,760	1,572,612	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	252,069	13,662	238,407	0	0	65.00
66.00	06600	PHYSICAL THERAPY	670,693	76,154	594,539	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	61,162	4,669	56,493	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	227,191	16,293	210,898	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	777,076	28,054	749,022	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,035,127	101,841	2,933,286	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	456,969	0	456,969	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	9,497,049	488,227	9,008,822	0	0	200.00
201.00		Less Observation Beds	456,969	0	456,969	0	0	201.00
202.00		Total (line 200 minus line 201)	9,040,080	488,227	8,551,853	0	0	202.00

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

Provider CCN: 151325

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

Worksheet C  
Part II  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	Cost
		6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	671,552	772,593	0.869218		50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	13,440	95,116	0.141301		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,701,398	6,299,125	0.270101		54.00
56.00	05600 RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700 CT SCAN	0	0	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000 LABORATORY	1,630,372	4,311,850	0.378114		60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000		63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	252,069	777,169	0.324343		65.00
66.00	06600 PHYSICAL THERAPY	670,693	1,656,330	0.404927		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	61,162	603,421	0.101359		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	227,191	1,273,231	0.178437		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	777,076	2,321,538	0.334725		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0.000000		90.00
91.00	09100 EMERGENCY	3,035,127	9,059,123	0.335035		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	456,969	371,994	1.228431		92.00
200.00	Subtotal (sum of lines 50 thru 199)	9,497,049	27,541,490			200.00
201.00	Less Observation Beds	456,969	0			201.00
202.00	Total (line 200 minus line 201)	9,040,080	27,541,490			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151325

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

Worksheet D  
Part II  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		Title XVIII			Hospital	Cost	
		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	92,477	772,593	0.119697	22,660	2,712	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	1,591	95,116	0.016727	1,422	24	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	95,726	6,299,125	0.015197	117,892	1,792	54.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	57,760	4,311,850	0.013396	249,296	3,340	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	13,662	777,169	0.017579	220,772	3,881	65.00
66.00	06600 PHYSICAL THERAPY	76,154	1,656,330	0.045978	56,658	2,605	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	4,669	603,421	0.007738	78,628	608	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16,293	1,273,231	0.012797	188,181	2,408	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	28,054	2,321,538	0.012084	444,874	5,376	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	101,841	9,059,123	0.011242	450	5	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	371,994	0.000000	0	0	92.00
200.00	Total (lines 50-199)	488,227	27,541,490		1,380,833	22,751	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		Title XVIII			Hospital	Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		Title XVIII			Hospital		Cost	
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	772,593	0.000000	0.000000	22,660	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	95,116	0.000000	0.000000	1,422	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,299,125	0.000000	0.000000	117,892	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	4,311,850	0.000000	0.000000	249,296	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	777,169	0.000000	0.000000	220,772	65.00
66.00	06600	PHYSICAL THERAPY	0	1,656,330	0.000000	0.000000	56,658	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	603,421	0.000000	0.000000	78,628	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,273,231	0.000000	0.000000	188,181	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,321,538	0.000000	0.000000	444,874	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	9,059,123	0.000000	0.000000	450	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	371,994	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	27,541,490			1,380,833	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		Title XVIII			Hospital		Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0			50.00
51.00	05100 RECOVERY ROOM	0	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
56.00	05600 RADIOISOTOPE	0	0			56.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
60.01	06001 BLOOD LABORATORY	0	0			60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
64.00	06400 INTRAVENOUS THERAPY	0	0			64.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0			90.00
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/19/2013 1:56 pm
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		Title XVIII		Hospital		Cost	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.869218	0	248,844	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.141301	0	27,808	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.270101	0	1,439,365	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.378114	0	1,142,843	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.324343	0	275,937	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.404927	0	224,175	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.101359	0	253,588	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.178437	0	211,082	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.334725	0	281,251	1,198	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.335035	0	1,459,564	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.228431	0	248,843	0	0	92.00
200.00	Subtotal (see instructions)		0	5,813,300	1,198	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	5,813,300	1,198	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/19/2013 1:56 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	216,300	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	3,929	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	388,774	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	432,125	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	89,498	0	65.00
66.00	06600 PHYSICAL THERAPY	90,775	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	25,703	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37,665	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	94,142	401	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	489,005	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	305,686	0	92.00
200.00	Subtotal (see instructions)	2,173,602	401	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	2,173,602	401	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 151325 Component CCN: 15M325		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part II Date/Time Prepared: 11/19/2013 1:56 pm	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	92,477	772,593	0.119697	2,856	342	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,591	95,116	0.016727	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	95,726	6,299,125	0.015197	72,064	1,095	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	57,760	4,311,850	0.013396	266,953	3,576	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	13,662	777,169	0.017579	31,302	550	65.00
66.00	06600	PHYSICAL THERAPY	76,154	1,656,330	0.045978	56,097	2,579	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,669	603,421	0.007738	54,828	424	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,293	1,273,231	0.012797	47,518	608	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,054	2,321,538	0.012084	358,772	4,335	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	101,841	9,059,123	0.011242	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	371,994	0.000000	0	0	92.00
200.00		Total (lines 50-199)	488,227	27,541,490		890,390	13,509	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325  
Component CCN: 15M325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/19/2013 1:56 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	772,593	0.000000	0.000000	2,856	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	95,116	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,299,125	0.000000	0.000000	72,064	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	4,311,850	0.000000	0.000000	266,953	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	777,169	0.000000	0.000000	31,302	65.00
66.00	06600	PHYSICAL THERAPY	0	1,656,330	0.000000	0.000000	56,097	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	603,421	0.000000	0.000000	54,828	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,273,231	0.000000	0.000000	47,518	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,321,538	0.000000	0.000000	358,772	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	9,059,123	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	371,994	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	27,541,490			890,390	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/19/2013 1:56 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325  
Component CCN: 15M325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/19/2013 1:56 pm

Title XVIII

Subprovider -  
IPF

PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151325

Period: From 07/01/2012

Worksheet D

Component CCN: 15Z325

To 06/30/2013

Part V  
Date/Time Prepared: 11/19/2013 1:56 pm

		Title XVIII		Swing Beds - SNF	Cost		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.869218	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.141301	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.270101	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRT)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.378114	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.324343	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.404927	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.101359	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.178437	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.334725	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.335035	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.228431	0	0	0	0	92.00
200.00	Subtotal (see instructions)		0	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges						201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151325

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

Worksheet D  
Part V  
Date/Time Prepared:  
11/19/2013 1:56 pm

Component CCN: 152325

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151325		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part I Date/Time Prepared: 11/19/2013 1:56 pm		
Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	ADULTS & PEDIATRICS	211,013	54,772	156,241	2,433	64.22	30.00	
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00	
40.00	SUBPROVIDER - IPF	151,043	0	151,043	3,217	46.95	40.00	
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00	
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00	
200.00	Total (lines 30-199)	362,056		307,284	5,650		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	ADULTS & PEDIATRICS	133	8,541					30.00
31.00	INTENSIVE CARE UNIT	0	0					31.00
40.00	SUBPROVIDER - IPF	0	0					40.00
41.00	SUBPROVIDER - IRF	0	0					41.00
42.00	SUBPROVIDER	0	0					42.00
200.00	Total (lines 30-199)	133	8,541					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151325

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

Worksheet D  
Part II  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		Title XIX			Hospital	Cost		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	92,477	772,593	0.119697	113,871	13,630	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,591	95,116	0.016727	11,692	196	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	95,726	6,299,125	0.015197	1,188,197	18,057	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	57,760	4,311,850	0.013396	552,598	7,403	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	13,662	777,169	0.017579	79,350	1,395	65.00
66.00	06600	PHYSICAL THERAPY	76,154	1,656,330	0.045978	2,358	108	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,669	603,421	0.007738	14,826	115	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,293	1,273,231	0.012797	137,538	1,760	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,054	2,321,538	0.012084	217,219	2,625	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	101,841	9,059,123	0.011242	3,935,012	44,237	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	371,994	0.000000	0	0	92.00
200.00		Total (lines 50-199)	488,227	27,541,490		6,252,661	89,526	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part III Date/Time Prepared: 11/19/2013 1:56 pm
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Cost Center Description	Title XIX				Hospital	Total Costs (sum of cols. 1 through 3, minus col. 4)
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Cost	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
200.00		Total (lines 30-199)	0	0	0	0	200.00

Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School
	6.00	7.00	8.00	9.00	11.00

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,433	0.00	133	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,217	0.00	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	42.00
200.00		Total (lines 30-199)	5,650		133	0	200.00

Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost
	12.00	13.00

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0			31.00
40.00	04000	SUBPROVIDER - IPF	0	0			40.00
41.00	04100	SUBPROVIDER - IRF	0	0			41.00
42.00	04200	SUBPROVIDER	0	0			42.00
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		Title XIX			Hospital	Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/19/2013 1:56 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	772,593	0.000000	0.000000	113,871	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	95,116	0.000000	0.000000	11,692	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	6,299,125	0.000000	0.000000	1,188,197	54.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	4,311,850	0.000000	0.000000	552,598	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	777,169	0.000000	0.000000	79,350	65.00
66.00	06600 PHYSICAL THERAPY	0	1,656,330	0.000000	0.000000	2,358	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	603,421	0.000000	0.000000	14,826	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,273,231	0.000000	0.000000	137,538	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,321,538	0.000000	0.000000	217,219	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	9,059,123	0.000000	0.000000	3,935,012	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	371,994	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	27,541,490			6,252,661	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description			Title XIX			Hospital		Cost
			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description			PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	Cost
			23.00	24.00			
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0			50.00
51.00	05100	RECOVERY ROOM	0	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300	ANESTHESIOLOGY	0	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0			54.00
56.00	05600	RADIOISOTOPE	0	0			56.00
57.00	05700	CT SCAN	0	0			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000	LABORATORY	0	0			60.00
60.01	06001	BLOOD LABORATORY	0	0			60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
64.00	06400	INTRAVENOUS THERAPY	0	0			64.00
65.00	06500	RESPIRATORY THERAPY	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0			90.00
91.00	09100	EMERGENCY	0	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00		Total (lines 50-199)	0	0			200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/19/2013 1:56 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,606 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,433 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,887 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			398 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)			398 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			188 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)			189 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,118 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)			398 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)			398 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			126.36 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			126.36 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,750,127 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)			23,756 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)			23,882 25.00
26.00	Total swing-bed cost (see instructions)			713,842 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,036,285 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,036,285 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			836.94 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			935,699 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)			935,699 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1		
Date/Time Prepared: 11/19/2013 1:56 pm		Title XVIII		Hospital		Cost		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
	1.00	2.00	3.00	4.00	5.00			
42.00	NURSERY (title V & XIX only)							42.00
	<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00	0	0	0.00	0	0		43.00	
44.00							44.00	
45.00							45.00	
46.00							46.00	
47.00							47.00	
	Cost Center Description							
						1.00		
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)						431,159	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						1,366,858	49.00
	<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
	<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
	<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						333,102	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						333,102	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						666,204	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
	<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
	<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00	Total observation bed days (see instructions)						546	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						836.94	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						456,969	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/19/2013 1:56 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Hospital Total Observation Bed Cost (from line 89)	Cost Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/19/2013 1:56 pm
Cost Center Description		Title XVIII	Subprovider - IPF	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,217 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,217 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)			3,217 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)			2,916 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			126.36 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			126.36 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,702,453 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)			2,702,453 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,702,453 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			840.05 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,449,586 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			2,449,586 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325 Component CCN: 15M325		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/19/2013 1:56 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					289,880	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,739,466	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					13,509	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					13,509	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,725,957	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325 Component CCN: 15M325		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/19/2013 1:56 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
90.00	Capital-related cost	0	2,702,453	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,702,453	0.000000	0	0	91.00
92.00	Allied health cost	0	2,702,453	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,702,453	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/19/2013 1:56 pm
Cost Center Description		Title XIX	Hospital	cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,606 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,433 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,887 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			398 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)			398 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			168 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)			209 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			133 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			126.36 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			126.36 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,750,127 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)			21,228 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)			26,409 25.00
26.00	Total swing-bed cost (see instructions)			713,841 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,036,286 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,036,286 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			836.94 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			111,313 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)			111,313 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Date/Time Prepared: 11/19/2013 1:56 pm	
Cost Center Description		1.00	2.00	3.00	4.00	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)						42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					2,074,322	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,185,635	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00	Total observation bed days (see instructions)					546	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					836.94	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					456,969	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:151325		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/19/2013 1:56 pm	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Hospital		Cost	
	1.00	2.00	3.00	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/19/2013 1:56 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital		Cost
		1.00	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000		ADULTS & PEDIATRICS	780,093	30.00
31.00	03100		INTENSIVE CARE UNIT	0	31.00
40.00	04000		SUBPROVIDER - IPF	0	40.00
41.00	04100		SUBPROVIDER - IRF	0	41.00
42.00	04200		SUBPROVIDER	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	0.869218	OPERATING ROOM	22,660	50.00
51.00	05100	0.000000	RECOVERY ROOM	0	51.00
52.00	05200	0.000000	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	0.141301	ANESTHESIOLOGY	1,422	53.00
54.00	05400	0.270101	RADIOLOGY-DIAGNOSTIC	117,892	54.00
56.00	05600	0.000000	RADIOISOTOPE	0	56.00
57.00	05700	0.000000	CT SCAN	0	57.00
58.00	05800	0.000000	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	0.000000	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	0.378114	LABORATORY	249,296	60.00
60.01	06001	0.000000	BLOOD LABORATORY	0	60.01
63.00	06300	0.000000	BLOOD STORING, PROCESSING & TRANS.	0	63.00
64.00	06400	0.000000	INTRAVENOUS THERAPY	0	64.00
65.00	06500	0.324343	RESPIRATORY THERAPY	220,772	65.00
66.00	06600	0.404927	PHYSICAL THERAPY	56,658	66.00
67.00	06700	0.000000	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	0.000000	SPEECH PATHOLOGY	0	68.00
69.00	06900	0.101359	ELECTROCARDIOLOGY	78,628	69.00
71.00	07100	0.178437	MEDICAL SUPPLIES CHARGED TO PATIENTS	188,181	71.00
72.00	07200	0.000000	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	0.334725	DRUGS CHARGED TO PATIENTS	444,874	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	0.000000	CLINIC	0	90.00
91.00	09100	0.335035	EMERGENCY	450	91.00
92.00	09200	1.228431	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
200.00			Total (sum of lines 50-94 and 96-98)	1,380,833	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)	1,380,833	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/19/2013 1:56 pm	
Cost Center Description		Title XVIII	Subprovider - IPF	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		3,711,234	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.869218	2,856	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.141301	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.270101	72,064	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.378114	266,953	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.324343	31,302	65.00
66.00	06600	PHYSICAL THERAPY	0.404927	56,097	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.101359	54,828	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.178437	47,518	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.334725	358,772	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.335035	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.228431	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		890,390	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)		890,390	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	worksheet D-3
		Component CCN: 152325		Date/Time Prepared: 11/19/2013 1:56 pm
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS		
31.00	03100	INTENSIVE CARE UNIT	514,268	30.00
40.00	04000	SUBPROVIDER - IPF	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	40.00
42.00	04200	SUBPROVIDER	0	41.00
42.00			0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	1,428	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,372	54.00
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	79,256	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	76,882	65.00
66.00	06600	PHYSICAL THERAPY	357,748	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,830	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	63,579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	167,770	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)	766,865	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)	766,865	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3	
		Title XIX		Hospital	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		49,964	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.869218	113,871	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.141301	11,692	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.270101	1,188,197	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.378114	552,598	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.324343	79,350	65.00
66.00	06600	PHYSICAL THERAPY	0.404927	2,358	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.101359	14,826	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.178437	137,538	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.334725	217,219	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.335035	3,935,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.228431	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		6,252,661	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		6,252,661	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/19/2013 1:56 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			2,174,003 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			2,174,003 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			2,195,743 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			12,892 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			933,439 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)			1,249,412 27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,249,412 30.00
31.00	Primary payer payments			1,421 31.00
32.00	Subtotal (line 30 minus line 31)			1,247,991 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			253,851 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			253,851 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			228,687 36.00
37.00	Subtotal (see instructions)			1,501,842 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00				0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			1,501,842 40.00
40.01	Sequestration adjustment (see instructions)			7,509 40.01
41.00	Interim payments			1,432,335 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			61,998 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				Overrides
				1.00
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 151325		Period: From 07/01/2012 To 06/30/2013		Worksheet E-1 Part I Date/Time Prepared: 11/19/2013 1:56 pm	
		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		978,311		1,287,735		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
<b>Program to Provider</b>							
3.01	ADJUSTMENTS TO PROVIDER	02/27/2013	159,800	02/27/2013	144,600		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
<b>Provider to Program</b>							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		159,800		144,600		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)		1,138,111		1,432,335		4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
<b>Program to Provider</b>							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
<b>Provider to Program</b>							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		50,177		69,507		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		1,188,288		1,501,842		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
			0	1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151325  
Component CCN: 15M325

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/19/2013 1:56 pm  
PPS

Title XVIII

Subprovider -  
IPF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,058,632		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
<b>Program to Provider</b>						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
<b>Provider to Program</b>						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		2,058,632		0	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
<b>Program to Provider</b>						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
<b>Provider to Program</b>						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		10,419		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,069,051		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151325

Period: From 07/01/2012

Worksheet E-1

Component CCN: 15Z325

To 06/30/2013

Part I

Date/Time Prepared: 11/19/2013 1:56 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		788,313			0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
<b>Program to Provider</b>							
3.01	ADJUSTMENTS TO PROVIDER	02/27/2013	131,500			0	3.01
3.02			0			0	3.02
3.03			0			0	3.03
3.04			0			0	3.04
3.05			0			0	3.05
<b>Provider to Program</b>							
3.50	ADJUSTMENTS TO PROGRAM		0			0	3.50
3.51			0			0	3.51
3.52			0			0	3.52
3.53			0			0	3.53
3.54			0			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		131,500			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)		919,813			0	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
<b>Program to Provider</b>							
5.01	TENTATIVE TO PROVIDER		0			0	5.01
5.02			0			0	5.02
5.03			0			0	5.03
<b>Provider to Program</b>							
5.50	TENTATIVE TO PROGRAM		0			0	5.50
5.51			0			0	5.51
5.52			0			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		20,813			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		940,626			0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
			0	1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151325	Period: From 07/01/2012	Worksheet E-2
		Component CCN: 15Z325	To 06/30/2013	Date/Time Prepared: 11/19/2013 1:56 pm
		Title XVIII	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		672,866	0
2.00	Inpatient routine services - swing bed-NF (see instructions)			0
3.00	Ancillary services (from wkst. D-3, column 3, line 200 for Part A, and sum of wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)		275,883	0
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00
5.00	Program days		796	0
6.00	Interns and residents not in approved teaching program (see instructions)			0
7.00	Utilization review - physician compensation - SNF optional method only		0	0
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		948,749	0
9.00	Primary payer payments (see instructions)		0	0
10.00	Subtotal (line 8 minus line 9)		948,749	0
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0
12.00	Subtotal (line 10 minus line 11)		948,749	0
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		8,123	0
14.00	80% of Part B costs (line 12 x 80%)			0
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		940,626	0
16.00			0	0
17.00	Allowable bad debts (see instructions)		0	0
17.01	Adjusted reimbursable bad debts (see instructions)		0	0
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0
19.00	Total (see instructions)		940,626	0
19.01	Sequestration adjustment (see instructions)		4,703	0
20.00	Interim payments		919,813	0
21.00	Tentative settlement (for contractor use only)		0	0
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21		16,110	0
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part V Date/Time Prepared: 11/19/2013 1:56 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)</b>				
1.00	Inpatient services			1,366,858 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			1,366,858 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,380,527 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,380,527 19.00
20.00	Deductibles (exclude professional component)			223,567 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			1,156,960 22.00
23.00	Coinsurance			15,210 23.00
24.00	Subtotal (line 22 minus line 23)			1,141,750 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			46,538 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			46,538 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			14,170 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,188,288 28.00
29.00				0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			1,188,288 30.00
30.01	Sequestration adjustment (see instructions)			5,941 30.01
31.00	Interim payments			1,138,111 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32			44,236 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part II Date/Time Prepared: 11/19/2013 1:56 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,255,671 1.00
2.00	Net IPF PPS Outlier Payments			4,437 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			8.813699 9.00
10.00	Indirect Medical Education Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1)\}$ .			0.000000 10.00
11.00	Indirect Medical Education Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2,260,108 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,260,108 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,260,108 18.00
19.00	Deductibles			141,416 19.00
20.00	Subtotal (line 18 minus line 19)			2,118,692 20.00
21.00	Coinsurance			49,641 21.00
22.00	Subtotal (line 20 minus line 21)			2,069,051 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,069,051 26.00
27.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00				0 30.00
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			2,069,051 31.00
31.01	Sequestration adjustment (see instructions)			10,345 31.01
32.00	Interim payments			2,058,632 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33			74 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from worksheet E-3, Part II, line 2			4,437 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 11/19/2013 1:56 pm
		Title XIX	Hospital	Cost
			Inpatient	Outpatient
			1.00	2.00
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services		2,185,635	1.00
2.00	Medical and other services			0 2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		2,185,635	0 4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments			0 6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		2,185,635	0 7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges		49,964	8.00
9.00	Ancillary service charges		6,252,661	0 9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		6,302,625	0 12.00
<b>CUSTOMARY CHARGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0 13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0 14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000 15.00
16.00	Total customary charges (see instructions)		6,302,625	0 16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		4,116,990	0 17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0 18.00
19.00	Interns and Residents (see instructions)		0	0 19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0 20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		2,185,635	0 21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>				
22.00	Other than outlier payments		0	0 22.00
23.00	Outlier payments		0	0 23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0 26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0 27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0 28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		2,185,635	0 29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)		0	0 30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2,185,635	0 31.00
32.00	Deductibles		0	0 32.00
33.00	Coinsurance		0	0 33.00
34.00	Allowable bad debts (see instructions)		-17,708	0 34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		2,167,927	0 36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0 37.00
38.00	Subtotal (line 36 ± line 37)		2,167,927	0 38.00
39.00	Direct graduate medical education payments (from wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		2,167,927	0 40.00
41.00	Interim payments		2,167,927	0 41.00
42.00	Balance due provider/program (line 40 minus 41)		0	0 42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0 43.00

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

Provider CCN: 151325

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

Worksheet G

Date/Time Prepared:  
11/19/2013 1:56 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	254,397	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	4,001,380	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,010,746	0	0	0	6.00
7.00	Inventory	155,851	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	149,431	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)	2,550,313	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	445,242	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	11,593,962	0	0	0	15.00
16.00	Accumulated depreciation	-7,762,239	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	7,790,395	0	0	0	19.00
20.00	Accumulated depreciation	-6,157,454	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,909,906	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	39,013	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	239,513	470,855	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	278,526	470,855	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	8,738,745	470,855	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	383,906	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	65,790	0	0	0	39.00
40.00	Notes and loans payable (short term)	97,518	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	4,659,359	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,206,573	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	4,365,714	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,149,963	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,515,677	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,722,250	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	-1,983,505	0	0	0	52.00
53.00	Specific purpose fund	0	470,855	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-1,983,505	470,855	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,738,745	470,855	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151325

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

Worksheet G-1

Date/Time Prepared:  
11/19/2013 1:56 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-286,843		455,346		1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		-1,763,161				2.00
3.00	Total (sum of line 1 and line 2)		-2,050,004		455,346		3.00
4.00	DEFERRED PENSION COSTS	68,003		0		0	4.00
5.00	ROUNDING	2		0		0	5.00
6.00	TEMP RESTRICTED CONTRIB	0		15,509		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		68,005		15,509		10.00
11.00	Subtotal (line 3 plus line 10)		-1,981,999		470,855		11.00
12.00	TRANSFER TO AFFILIATES	1,506		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1,506		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,983,505		470,855		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	DEFERRED PENSION COSTS		0				4.00
5.00	ROUNDING		0				5.00
6.00	TEMP RESTRICTED CONTRIB		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	TRANSFER TO AFFILIATES		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151325

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/19/2013 1:56 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital	2,171,875		2,171,875	1.00
2.00	SUBPROVIDER - IPF	4,105,004		4,105,004	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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)	6,276,879		6,276,879	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,276,879		6,276,879	17.00
18.00	Ancillary services	5,194,510	14,347,816	19,542,326	18.00
19.00	Outpatient services	0	14,374,066	14,374,066	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	NRCC	0	184,947	184,947	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	11,471,389	28,906,829	40,378,218	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per wkst. A, column 3, line 200)		15,961,585		29.00
30.00	BAD DEBTS	4,842,964			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)		4,842,964		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		20,804,549		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 151325	Period: From 07/01/2012 To 06/30/2013	Worksheet G-3 Date/Time Prepared: 11/19/2013 1:56 pm
				1.00
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)			40,378,218 1.00
2.00	Less contractual allowances and discounts on patients' accounts			21,365,472 2.00
3.00	Net patient revenues (line 1 minus line 2)			19,012,746 3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)			20,804,549 4.00
5.00	Net income from service to patients (line 3 minus line 4)			-1,791,803 5.00
<b>OTHER INCOME</b>				
6.00	Contributions, donations, bequests, etc			0 6.00
7.00	Income from investments			5,515 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			37,116 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			2,689 21.00
22.00	Rental of hospital space			0 22.00
23.00	Governmental appropriations			0 23.00
24.00	OTHER OPERATING REVENUE			12,945 24.00
24.01	EXERCISE REVENUE			22,048 24.01
24.02	HOUSEKEEPING REVENUE			7,370 24.02
24.03	OTHER MAINTENANCE REVENUE			2,011 24.03
24.04	GRANT REVENUE			12,249 24.04
24.05	INCOME - GENESIS			1,436 24.05
24.06	OTHER OPERATING REVENUE			151,370 24.06
24.07	GAIN/LOSS ON SALE OF ASSETS			-14,238 24.07
24.08				0 24.08
24.09				0 24.09
25.00	Total other income (sum of lines 6-24)			240,511 25.00
26.00	Total (line 5 plus line 25)			-1,551,292 26.00
27.00	OTHER EXPENSES (SPECIFY)			211,869 27.00
28.00	Total other expenses (sum of line 27 and subscripts)			211,869 28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			-1,763,161 29.00

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

Provider Name: ST. MARY'S WARRICK HOSPITAL, INC.

Health Financial Systems

Provider No: 151325

MCRIF32

<b>Allocation of Physician Compensation: Hours</b>	<b>Provider:</b>	ST. MARY'S WARRICK HOSPITAL, INC.
<b>Department:</b> EMERGENCY DEPARTMENT	<b>Number:</b>	151325
<b>Physician:</b> AGGREGATE EMERGENCY ROOM PHYSICIANS	<b>Specialty:</b>	EMERGENCY MEDICINE-GENERAL

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

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Health Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	6043.50
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	6043.50
2. Physician Services: Medical and Surgical Services to Individual Patients.	2716.50
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	8760.00
5. Professional Component Percentage (Line 2 / Line 4)	31.01 %
6. Provider Component Percentage - (Line 1D / Line 4)	68.99 %

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Signature: Physician or Physician Department Head

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Date

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

Provider Name: ST. MARY'S WARRICK HOSPITAL, INC.

Health Financial Systems

Provider No: 151325

MCRIF32

<b>Allocation of Physician Compensation: Hours</b>	<b>Provider:</b>	ST. MARY'S WARRICK HOSPITAL, INC.
<b>Department:</b> EMERGENCY DEPARTMENT	<b>Number:</b>	151325
<b>Physician:</b> AGGREGATE OPERATING ROOM PHYSICIANS	<b>Specialty:</b>	SURGERY-GENERAL

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

Signature: Physician or Physician Department Head

Date

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

Provider Name: ST. MARY'S WARRICK HOSPITAL, INC.

Health Financial Systems

Provider No: 151325

MCRIF32

<b>Allocation of Physician Compensation: Hours</b>	<b>Provider:</b>	ST. MARY'S WARRICK HOSPITAL, INC.
<b>Department:</b> EMERGENCY DEPARTMENT	<b>Number:</b>	151325
<b>Physician:</b> AGGREGATE ANESTHESIOLOGY PHYSICIANS	<b>Specialty:</b>	ANESTHESIOLOGY-GENERAL

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

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

Signature: Physician or Physician Department Head

Date

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

Provider Name: ST. MARY'S WARRICK HOSPITAL, INC.

Health Financial Systems

Provider No: 151325

MCRIF32

**Allocation of Physician Compensation: Hours**  
**Department:** EMERGENCY DEPARTMENT  
**Physician:** AGGREGATE RADIOLOGY PHYSICIANS

**Provider:** ST. MARY'S WARRICK HOSPITAL, INC.  
**Number:** 151325  
**Specialty:** RADIOLOGY, DIAGNOSTIC-GENERAL

**Basis of Allocation:** Time Study

**Describe:**

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

Signature: Physician or Physician Department Head

Date

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

Provider Name: ST. MARY'S WARRICK HOSPITAL, INC.

Health Financial Systems

Provider No: 151325

MCRIF32

<b>Allocation of Physician Compensation: Hours</b>	<b>Provider:</b> ST. MARY'S WARRICK HOSPITAL, INC.
<b>Department:</b> EMERGENCY DEPARTMENT	<b>Number:</b> 151325
<b>Physician:</b> AGGREGATE RESPIRATORY THERAPY PHYSICIANS	<b>Specialty:</b> CARDIOLOGY-GENERAL

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

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Signature: Physician or Physician Department Head	Date	

Date Prepared: 11/19/2013 2:24:22 PM

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

Provider Name: ST. MARY'S WARRICK HOSPITAL, INC.

Health Financial Systems

Provider No: 151325

MCRIF32

**Allocation of Physician Compensation: Hours**

**Department:** EMERGENCY DEPARTMENT

**Physician:** AGGREGATE ELECTROCARDIOLOGY PHYSICIANS

**Provider:** ST. MARY'S WARRICK HOSPITAL, INC.

**Number:** 151325

**Specialty:** CARDIOLOGY-GENERAL

**Basis of Allocation:** Time Study

**Describe:**

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

Signature: Physician or Physician Department Head

Date

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