

St. Vincent Dunn Hospital

Provider No. 15-1335, 15-Z335, and Aim No. 100268040A

**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: 151335 Period: From 07/01/2012 To 06/30/2013 Worksheet 5 Parts I-III Date/Time Prepared: 11/26/2013 1:29 pm

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 11/26/2013 Time: 1:29 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 6. Date Received:
 (2) Settled without Audit 7. Contractor No.
 (3) Settled with Audit 8. Initial Report for this Provider CCN
 (4) Reopened 9. Final Report for this Provider CCN
 (5) Amended 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 VINCENT DUNN (151335) 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: 11/26/2013 Time: 1:29 pm
 pk2TmOK0WwOvdVpkRYcfXwVQWfuzz0
 nqt4F0SddxJCmN4LGryTgdj1h5:E7d
 Q5cL08m.G.0F7BKD
 PI: Date: 11/26/2013 Time: 1:29 pm
 YpUwqqQn1EcBfInLcQQ.3vs1x0HuV0
 CDLY70cwcLboTR4jus1k19ro:Khb.
 Gp2i0NsJfQ0BfcOu

(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			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-544,954	-240,816	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	28,192	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
200.00 Total	0	-516,762	-240,816	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: 151335	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 1:17 pm
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	1.00	2.00	3.00	4.00		
Hospital and Hospital Health Care Complex Address:						
1.00	Street: 1616 TWENTY-THIRD STREET		PO Box:		1.00	
2.00	City: BEDFORD		State: IN	Zip Code: 47421	County: LAWRENCE	
	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)
						V XVIII XIX
	1.00	2.00	3.00	4.00	5.00	6.00 7.00 8.00

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ST VINCENT DUNN	151335	99915	1	07/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT DUNN	152335	99915		03/03/2012	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)			21.00

Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							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	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151335	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 1:17 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		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151335	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 1:17 pm		
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 66.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151335

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

Worksheet S-2
Part I
Date/Time Prepared:
11/26/2013 1:17 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	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000			67.00
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)						0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)						0	76.00
					1.00			
Long Term Care Hospital PPS								
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.						N	80.00
TEFRA Providers								
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.						N	85.00
86.00	Did this facility establish a new other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							86.00
					V	XIX		
					1.00	2.00		
Title V and XIX Services								
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.				N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.				N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.				N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.				N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.				N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00
Rural Providers								
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?				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			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.	N	N	N	N	109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2			118.00
			Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:		88,294	0	0	118.01
				1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N		N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		15H046	140.00

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1.00		2.00		3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08101		141.00		
142.00	Street: 10330 N. MERIDIAN ST.	PO Box:				142.00		
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46290		143.00		
1.00								
144.00	Are provider based physicians' costs included in worksheet A?						Y	
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	
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	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N			
156.00	Subprovider - IPF	N	N	N	N			
157.00	Subprovider - IRF	N	N	N	N			
158.00	SUBPROVIDER							
159.00	SNF	N	N	N	N			
160.00	HOME HEALTH AGENCY	N	N	N	N			
161.00	CMHC		N	N	N			
1.00								
165.00	Multicampus 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	
		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								
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	
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	
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)							

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151335	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/26/2013 1:17 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "v" for voluntary or "i" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.		N		11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
Description			Y/N	Date	Y/N
0			1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		Y	10/02/2013	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

	Description	Part A		Part B	
		Y/N	Date	Y/N	
	0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151335	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/26/2013 1:17 pm
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		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	10/02/2013	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	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

		Title V	Title XIX	
		1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
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	
CRITICAL ACCESS HOSPITALS				
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	
RCE DISALLOWANCE				
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
PASS THROUGH COST				
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: 151335

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

Worksheet S-3
Part I
Date/Time Prepared:
11/26/2013 1:17 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	Title V
	Line Number				Visits / Trips	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	8,949	76,656.00	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	8,949	76,656.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	176	168.00	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	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	76,824.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151335

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

Worksheet S-3
Part I
Date/Time Prepared:
11/26/2013 1:17 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,836	98	3,194			1.00
2.00 HMO and other (see instructions)	172	447				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	214	0	214			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		13	37			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,050	111	3,445			7.00
8.00 INTENSIVE CARE UNIT	7	0	7			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		38	520			13.00
14.00 Total (see instructions)	2,057	149	3,972	0.00	178.35	14.00
15.00 CAH visits	10,902	1,638	32,786			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	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	178.35	27.00
28.00 Observation Bed Days		0	654			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			48			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		5	127			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	456	243	1,173	1.00
2.00 HMO and other (see instructions)				51			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	456		243	1,173	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY	0.00						19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						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: 151335	Period: From 07/01/2012 To 06/30/2013	Worksheet S-10 Date/Time Prepared: 11/26/2013 1:17 pm
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.418201	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	681,688		5.00
6.00	Medicaid charges	8,098,599		6.00
7.00	Medicaid cost (line 1 times line 6)	3,386,842		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,705,154		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	198,136		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,705,154		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,892,417	356	2,892,773
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,209,612	149	1,209,761
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,209,612	149	1,209,761
				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)	1,005,029		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	524,987		27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)	480,042		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	200,754		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,410,515		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,115,669		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151335

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

Worksheet A

Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		836,148	836,148	-35,147	801,001	1.00
2.00	00200		571,113	571,113	0	571,113	2.00
4.00	00400	213,154	3,046,844	3,259,998	-6	3,259,992	4.00
5.00	00500	1,433,633	2,789,353	4,222,986	34,225	4,257,211	5.00
7.00	00700	261,218	1,673,537	1,934,755	-652	1,934,103	7.00
8.00	00800	0	82,986	82,986	0	82,986	8.00
9.00	00900	0	478,389	478,389	0	478,389	9.00
10.00	01000	0	721,879	721,879	-487,144	234,735	10.00
11.00	01100	0	0	0	487,103	487,103	11.00
13.00	01300	227,874	37,484	265,358	-62,064	203,294	13.00
14.00	01400	130,674	1,212	131,886	0	131,886	14.00
15.00	01500	390,355	788,342	1,178,697	19,354	1,198,051	15.00
16.00	01600	703,424	387,805	1,091,229	-195	1,091,034	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,406,391	207,632	2,614,023	-628,274	1,985,749	30.00
31.00	03100	28,558	1,397	29,955	0	29,955	31.00
43.00	04300	0	0	0	222,368	222,368	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	723,317	654,561	1,377,878	-366,099	1,011,779	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	442,189	442,189	52.00
53.00	05300	0	4,638	4,638	0	4,638	53.00
54.00	05400	724,844	404,127	1,128,971	-26,782	1,102,189	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	58,875	215,103	273,978	-99,484	174,494	59.00
60.00	06000	0	1,703,972	1,703,972	-804	1,703,168	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	388,682	20,669	409,351	-162	409,189	65.00
66.00	06600	215,231	20,698	235,929	-440	235,489	66.00
67.00	06700	30,673	2,354	33,027	68	33,095	67.00
68.00	06800	8,138	307	8,445	0	8,445	68.00
69.00	06900	230,968	63,201	294,169	-497	293,672	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	12,395	12,395	506,917	519,312	71.00
72.00	07200	0	127,576	127,576	0	127,576	72.00
73.00	07300	0	0	0	0	0	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	24,835	2,063	26,898	-89	26,809	75.01
76.97	07697	62,005	1,873	63,878	0	63,878	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	823,391	825,902	1,649,293	-4,300	1,644,993	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		9,086,240	15,683,560	24,769,800	85	24,769,885	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	13,477	4,517	17,994	0	17,994	194.00
194.01	07951	31,605	549	32,154	0	32,154	194.01
194.02	07952	132,606	21,528	154,134	-85	154,049	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	10,816	10,816	0	10,816	194.06
200.00		9,263,928	15,720,970	24,984,898	0	24,984,898	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151335

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

Worksheet A
Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-153,518	647,483	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,521	569,592	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	228,984	3,488,976	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-150,301	4,106,910	5.00
7.00	00700	OPERATION OF PLANT	-2,253	1,931,850	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	82,986	8.00
9.00	00900	HOUSEKEEPING	0	478,389	9.00
10.00	01000	DIETARY	0	234,735	10.00
11.00	01100	CAFETERIA	-88,279	398,824	11.00
13.00	01300	NURSING ADMINISTRATION	-452	202,842	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	131,886	14.00
15.00	01500	PHARMACY	-887	1,197,164	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-16,862	1,074,172	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-36,028	1,949,721	30.00
31.00	03100	INTENSIVE CARE UNIT	0	29,955	31.00
43.00	04300	NURSERY	0	222,368	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,011,779	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	442,189	52.00
53.00	05300	ANESTHESIOLOGY	0	4,638	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,102,189	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	174,494	59.00
60.00	06000	LABORATORY	0	1,703,168	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	409,189	65.00
66.00	06600	PHYSICAL THERAPY	0	235,489	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	33,095	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,445	68.00
69.00	06900	ELECTROCARDIOLOGY	-50,616	243,056	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	519,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	127,576	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	SLEEP DISORDER	0	26,809	75.01
76.97	07697	CARDIAC REHABILITATION	0	63,878	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-136,674	1,508,319	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-408,407	24,361,478	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	MARKETING	207,110	225,104	194.00
194.01	07951	FOUNDATION	0	32,154	194.01
194.02	07952	COMMUNITY OUTREACH	0	154,049	194.02
194.03	07953	WIC	0	0	194.03
194.04	07954	GRANTS	0	0	194.04
194.05	07955	VACANT SPACE	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	10,816	194.06
200.00		TOTAL (SUM OF LINES 118-199)	-201,297	24,783,601	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 151335

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

Worksheet Non-CMS W

Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
64.00	INTRAVENOUS THERAPY	06400		64.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
75.00	ASC (NON-DISTINCT PART)	07500		75.00
75.01	SLEEP DISORDER	07501		75.01
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	09500		95.00
101.00	HOME HEALTH AGENCY	10100		101.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
193.00	NONPAID WORKERS	19300		193.00
194.00	MARKETING	07950		194.00
194.01	FOUNDATION	07951		194.01
194.02	COMMUNITY OUTREACH	07952		194.02
194.03	WIC	07953		194.03
194.04	GRANTS	07954		194.04
194.05	VACANT SPACE	07955		194.05
194.06	OLD AMBULANCE CENTER	07956		194.06
200.00	TOTAL (SUM OF LINES 118-199)			200.00

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
A - CAFETERIA						
1.00	CAFETERIA		11.00	0	487,103	1.00
	TOTALS			0	487,103	
B - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL		5.00	0	35,147	1.00
	TOTALS			0	35,147	
C - NURSERY AND OB						
1.00	NURSERY		43.00	193,023	29,345	1.00
2.00	DELIVERY ROOM & LABOR ROOM		52.00	383,835	58,354	2.00
	TOTALS			576,858	87,699	
D - MED SURG ASSOCIATES						
1.00	ADULTS & PEDIATRICS		30.00	62,047	0	1.00
	TOTALS			62,047	0	
E - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0	506,917	1.00
2.00	PHARMACY		15.00	0	197	2.00
3.00	OCCUPATIONAL THERAPY		67.00	0	68	3.00
4.00	PHARMACY		15.00	0	19,157	4.00
5.00			0.00	0	0	5.00
6.00			0.00	0	0	6.00
7.00			0.00	0	0	7.00
8.00			0.00	0	0	8.00
9.00			0.00	0	0	9.00
10.00			0.00	0	0	10.00
11.00			0.00	0	0	11.00
12.00			0.00	0	0	12.00
13.00			0.00	0	0	13.00
14.00			0.00	0	0	14.00
16.00			0.00	0	0	16.00
17.00			0.00	0	0	17.00
18.00			0.00	0	0	18.00
19.00			0.00	0	0	19.00
	TOTALS			0	526,339	
500.00	Grand Total: Increases			638,905	1,136,288	500.00

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - CAFETERIA						
1.00	DIETARY	10.00	0	487,103	0	1.00
	TOTALS		0	487,103		
B - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	35,147	9	1.00
	TOTALS		0	35,147		
C - NURSERY AND OB						
1.00	ADULTS & PEDIATRICS	30.00	576,858	87,699	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		576,858	87,699		
D - MED SURG ASSOCIATES						
1.00	NURSING ADMINISTRATION	13.00	62,047	0	0	1.00
	TOTALS		62,047	0		
E - MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	922	0	2.00
3.00	OPERATION OF PLANT	7.00	0	652	0	3.00
4.00	DIETARY	10.00	0	41	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	17	0	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	195	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	25,764	0	7.00
8.00	OPERATING ROOM	50.00	0	366,099	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,625	0	9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	99,484	0	10.00
11.00	LABORATORY	60.00	0	804	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	162	0	12.00
13.00	PHYSICAL THERAPY	66.00	0	440	0	13.00
14.00	ELECTROCARDIOLOGY	69.00	0	497	0	14.00
16.00	SLEEP DISORDER	75.01	0	89	0	16.00
17.00	EMERGENCY	91.00	0	4,300	0	17.00
18.00	COMMUNITY OUTREACH	194.02	0	85	0	18.00
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	19,157	0	19.00
	TOTALS		0	526,339		
500.00	Grand Total: Decreases		638,905	1,136,288		500.00

Increases			Decreases		
Cost Center	Line #	Salary	Cost Center	Line #	Salary
2.00	3.00	4.00	6.00	7.00	8.00
A - CAFETERIA					
1.00	CAFETERIA	11.00	0	DIETARY	10.00
	TOTALS		0	TOTALS	0
B - INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	CAP REL COSTS-BLDG & FIXT	1.00
	TOTALS		0	TOTALS	0
C - NURSERY AND OB					
1.00	NURSERY	43.00	193,023	ADULTS & PEDIATRICS	30.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	383,835		0.00
	TOTALS		576,858	TOTALS	576,858
D - MED SURG ASSOCIATES					
1.00	ADULTS & PEDIATRICS	30.00	62,047	NURSING ADMINISTRATION	13.00
	TOTALS		62,047	TOTALS	62,047
E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	EMPLOYEE BENEFITS DEPARTMENT	4.00
2.00	PHARMACY	15.00	0	ADMINISTRATIVE & GENERAL	5.00
3.00	OCCUPATIONAL THERAPY	67.00	0	OPERATION OF PLANT	7.00
4.00	PHARMACY	15.00	0	DIETARY	10.00
5.00		0.00	0	NURSING ADMINISTRATION	13.00
6.00		0.00	0	MEDICAL RECORDS & LIBRARY	16.00
7.00		0.00	0	ADULTS & PEDIATRICS	30.00
8.00		0.00	0	OPERATING ROOM	50.00
9.00		0.00	0	RADIOLOGY-DIAGNOSTIC	54.00
10.00		0.00	0	CARDIAC CATHETERIZATION	59.00
11.00		0.00	0	LABORATORY	60.00
12.00		0.00	0	RESPIRATORY THERAPY	65.00
13.00		0.00	0	PHYSICAL THERAPY	66.00
14.00		0.00	0	ELECTROCARDIOLOGY	69.00
16.00		0.00	0	SLEEP DISORDER	75.01
17.00		0.00	0	EMERGENCY	91.00
18.00		0.00	0	COMMUNITY OUTREACH	194.02
19.00		0.00	0	RADIOLOGY-DIAGNOSTIC	54.00
	TOTALS		0	TOTALS	0
500.00	Grand Total: Increases		638,905	Grand Total: Decreases	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151335

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

Worksheet A-7
Part I
Date/Time Prepared:
11/26/2013 1:17 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	100,000	0	0	0	1.00
2.00	Land Improvements	60,000	0	0	0	2.00
3.00	Buildings and Fixtures	5,863,616	0	0	241,710	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	1,040,780	372,928	0	372,928	5.00
6.00	Movable Equipment	2,658,400	0	0	116,932	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	9,722,796	372,928	0	372,928	8.00
9.00	Reconciling Items	368,288	0	0	273,467	9.00
10.00	Total (line 8 minus line 9)	9,354,508	372,928	0	85,175	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	100,000	0			1.00
2.00	Land Improvements	60,000	0			2.00
3.00	Buildings and Fixtures	5,621,906	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	1,413,708	0			5.00
6.00	Movable Equipment	2,541,468	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	9,737,082	0			8.00
9.00	Reconciling Items	94,821	0			9.00
10.00	Total (line 8 minus line 9)	9,642,261	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151335

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

Worksheet A-7
Part II
Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	514,501	0	271,788	49,859	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	424,455	0	0	12,316	0	2.00
3.00	Total (sum of lines 1-2)	938,956	0	271,788	62,175	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	836,148				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	134,342	571,113				2.00
3.00	Total (sum of lines 1-2)	134,342	1,407,261				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151335

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

Worksheet A-7
Part III
Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	7,195,614	0	7,195,614	0.738991	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,541,468	0	2,541,468	0.261009	0	2.00
3.00	Total (sum of lines 1-2)	9,737,082	0	9,737,082	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	325,836	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	424,455	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	750,291	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	271,788	49,859	0	0	647,483	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	12,316	0	132,821	569,592	2.00
3.00	Total (sum of lines 1-2)	271,788	62,175	0	132,821	1,217,075	3.00

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	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-53,971	CAP REL COSTS-BLDG & FIXT	1.00	9 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	-8,016	ADMINISTRATIVE & GENERAL	5.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-2,796	OPERATION OF PLANT	7.00	0 7.00
8.00 Television and radio service (chapter 21)	A	-7,505	OPERATION OF PLANT	7.00	0 8.00
9.00 Parking lot (chapter 21)		0		0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-245,950			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	1,358,650			0 12.00
13.00 Laundry and linen service		0		0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-88,279	CAFETERIA	11.00	0 14.00
15.00 Rental of quarters to employee and others		0		0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0 16.00
17.00 Sale of drugs to other than patients		0		0.00	0 17.00
18.00 Sale of medical records and abstracts	B	-16,862	MEDICAL RECORDS & LIBRARY	16.00	0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0 19.00
20.00 Vending machines		0		0.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant		0		0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0 32.00
33.00 ENTERTAINMENT	A	-18	ADMINISTRATIVE & GENERAL	5.00	0 33.00
33.01 ENTERTAINMENT	A	-111	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.01

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		Line #	wkst. A-7 Ref.				
			1.00	2.00				3.00	4.00	5.00
33.02	LOSS ON FIXED ASSETS	A	-1,521	CAP REL COSTS-MVBLE EQUIP	2.00	14	33.02			
33.03			0		0.00	0	33.03			
33.04	LOBBYING OFFSET	A	-747	ADMINISTRATIVE & GENERAL	5.00	0	33.04			
33.05	MISC REVENUE	B	-1,380	ADULTS & PEDIATRICS	30.00	0	33.05			
33.06	MISC REVENUE	B	-887	PHARMACY	15.00	0	33.06			
33.07	MISC REVENUE	B	-37,755	ADMINISTRATIVE & GENERAL	5.00	0	33.07			
33.08	MISC REVENUE	B	-452	NURSING ADMINISTRATION	13.00	0	33.08			
33.11	HOSPITAL PROVIDER TAX	A	-843,161	ADMINISTRATIVE & GENERAL	5.00	0	33.11			
33.12	WIC GRANT	B	-173,606	ADMINISTRATIVE & GENERAL	5.00	0	33.12			
33.13	MATERNAL CHILD GRANT	B	-76,930	ADMINISTRATIVE & GENERAL	5.00	0	33.13			
33.14			0		0.00	0	33.14			
33.15			0		0.00	0	33.15			
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-201,297				50.00			

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

Provider CCN: 151335

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

Worksheet A-8-1

Date/Time Prepared: 11/26/2013 1:17 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
HOME OFFICE COSTS:					
1.00	0.00		0	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT HOME OFFICE	100,045	100,045	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL HOME OFFICE	2,697,433	1,502,887	3.00
4.00	194.00	MARKETING HOME OFFICE	207,110	0	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT SELF INSURANCE	1,768,676	1,539,581	4.01
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT ST VINCENT HLTH CHARGEBACK	59,775	59,775	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL ST VINCENT HLTH CHARGEBACK	90,540	90,540	4.03
4.04	7.00	OPERATION OF PLANT ST VINCENT HLTH CHARGEBACK	625	625	4.04
4.05	13.00	NURSING ADMINISTRATION ST VINCENT HLTH CHARGEBACK	927	927	4.05
4.06	14.00	CENTRAL SERVICES & SUPPLY ST VINCENT HLTH CHARGEBACK	131,508	131,508	4.06
4.07	16.00	MEDICAL RECORDS & LIBRARY ST VINCENT HLTH CHARGEBACK	12,072	12,072	4.07
4.08	54.00	RADIOLOGY-DIAGNOSTIC ST VINCENT HLTH CHARGEBACK	11,062	11,062	4.08
4.09	75.01	SLEEP DISORDER ST VINCENT HLTH CHARGEBACK	420	420	4.09
4.10	66.00	PHYSICAL THERAPY ST VINCENT HLTH CHARGEBACK	51,896	51,896	4.10
4.11	69.00	ELECTROCARDIOLOGY ST VINCENT HLTH CHARGEBACK	12,976	12,976	4.11
4.12	194.02	COMMUNITY OUTREACH ST VINCENT HLTH CHARGEBACK	13,832	13,832	4.12
4.13	7.00	OPERATION OF PLANT TRIMEDX	565,241	557,193	4.13
4.14	1.00	CAP REL COSTS-BLDG & FIXT ASCENSION INTEREST	137,094	236,641	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL ASCENSION INTEREST	20,362	35,147	4.15
4.16	4.00	EMPLOYEE BENEFITS DEPARTMENT ASCENSION PENSION	471,722	471,722	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL HOME OFFICE	0	165,817	4.17
4.18	1.00	CAP REL COSTS-BLDG & FIXT ASCENSION PAYMENTS	49,859	49,859	4.18
4.19	2.00	CAP REL COSTS-MVBLE EQUIP ASCENSION PAYMENTS	12,316	12,316	4.19
4.20	4.00	EMPLOYEE BENEFITS DEPARTMENT ASCENSION PAYMENTS	26,776	26,776	4.20
4.21	5.00	ADMINISTRATIVE & GENERAL ASCENSION PAYMENTS	101,229	101,229	4.21
4.22	13.00	NURSING ADMINISTRATION ASCENSION PAYMENTS	1,080	1,080	4.22
4.23	16.00	MEDICAL RECORDS & LIBRARY ASCENSION PAYMENTS	533	533	4.23
4.24	30.00	ADULTS & PEDIATRICS ASCENSION PAYMENTS	801	801	4.24
4.25	50.00	OPERATING ROOM ASCENSION PAYMENTS	267	267	4.25
4.26	91.00	EMERGENCY ASCENSION PAYMENTS	770	770	4.26
5.00	0		6,546,947	5,188,297	5.00

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

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

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

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

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

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

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

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

Provider CCN: 151335

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

Worksheet A-8-1

Date/Time Prepared:
11/26/2013 1:17 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0	1.00
2.00	0	0	2.00
3.00	1,194,546	0	3.00
4.00	207,110	0	4.00
4.01	229,095	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	8,048	0	4.13
4.14	-99,547	9	4.14
4.15	-14,785	0	4.15
4.16	0	0	4.16
4.17	-165,817	0	4.17
4.18	0	12	4.18
4.19	0	12	4.19
4.20	0	0	4.20
4.21	0	0	4.21
4.22	0	0	4.22
4.23	0	0	4.23
4.24	0	0	4.24
4.25	0	0	4.25
4.26	0	0	4.26
5.00	1,358,650		5.00

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

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

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

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

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

6.00	ADMINISTRATION	6.00
7.00	ADMINISTRATION	7.00
8.00	HOSPITAL	8.00
9.00	TRIMEDX	9.00
10.00		10.00
100.00		100.00

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

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- 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: 151335

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

Worksheet A-8-2

Date/Time Prepared:
11/26/2013 1:17 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	13.00	NURSING ADMINISTRATION	6,075	0	6,075	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	12,500	0	12,500	0	0	2.00
3.00	59.00	CARDIAC CATHETERIZATION	8,000	0	8,000	0	0	3.00
4.00	60.00	LABORATORY	12,680	0	12,680	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	50,616	50,616	0	0	0	5.00
6.00	91.00	EMERGENCY	764,862	136,674	628,188	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	34,648	34,648	0	0	0	7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	24,012	24,012	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			913,393	245,950	667,443	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	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	13.00	NURSING ADMINISTRATION	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	2.00
3.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	50,616	5.00
6.00	91.00	EMERGENCY	0	0	0	136,674	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	34,648	7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	24,012	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	245,950	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151335

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

Worksheet B
Part I
Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	647,483	647,483			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	569,592		569,592		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,488,976	21,946	19,306	3,530,228	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,106,910	100,429	88,348	559,184	4,854,871
7.00 00700	OPERATION OF PLANT	1,931,850	71,739	63,109	101,887	2,168,585
8.00 00800	LAUNDRY & LINEN SERVICE	82,986	12,027	10,580	0	105,593
9.00 00900	HOUSEKEEPING	478,389	11,172	9,828	0	499,389
10.00 01000	DIETARY	234,735	9,555	8,405	0	252,695
11.00 01100	CAFETERIA	398,824	24,706	21,734	0	445,264
13.00 01300	NURSING ADMINISTRATION	202,842	5,586	4,914	64,680	278,022
14.00 01400	CENTRAL SERVICES & SUPPLY	131,886	14,082	12,388	50,969	209,325
15.00 01500	PHARMACY	1,197,164	8,770	7,715	152,257	1,365,906
16.00 01600	MEDICAL RECORDS & LIBRARY	1,074,172	25,525	22,455	274,368	1,396,520
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,949,721	44,617	39,250	737,807	2,771,395
31.00 03100	INTENSIVE CARE UNIT	29,955	1,791	1,576	11,139	44,461
43.00 04300	NURSERY	222,368	2,607	2,294	75,288	302,557
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,011,779	65,695	57,792	282,128	1,417,394
51.00 05100	RECOVERY ROOM	0	0	0	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	442,189	35,910	31,590	149,714	659,403
53.00 05300	ANESTHESIOLOGY	4,638	1,309	1,151	0	7,098
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,102,189	32,000	28,151	282,723	1,445,063
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	174,494	2,271	1,997	22,964	201,726
60.00 06000	LABORATORY	1,703,168	25,129	22,106	0	1,750,403
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	409,189	7,871	6,924	151,604	575,588
66.00 06600	PHYSICAL THERAPY	235,489	12,551	11,041	83,950	343,031
67.00 06700	OCCUPATIONAL THERAPY	33,095	1,215	1,069	11,964	47,343
68.00 06800	SPEECH PATHOLOGY	8,445	247	217	3,174	12,083
69.00 06900	ELECTROCARDIOLOGY	243,056	9,857	8,671	90,088	351,672
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	519,312	0	0	0	519,312
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	127,576	0	0	0	127,576
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01 07501	SLEEP DISORDER	26,809	5,121	4,505	9,687	46,122
76.97 07697	CARDIAC REHABILITATION	63,878	4,663	4,102	24,185	96,828
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	1,508,319	20,505	18,038	321,161	1,868,023
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	24,361,478	578,896	509,256	3,460,921	24,163,248
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,170	1,909	0	4,079
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	64,577	56,808	0	121,385
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	MARKETING	225,104	1,139	1,002	5,257	232,502
194.01 07951	FOUNDATION	32,154	701	617	12,327	45,799
194.02 07952	COMMUNITY OUTREACH	154,049	0	0	51,723	205,772
194.03 07953	WIC	0	0	0	0	0
194.04 07954	GRANTS	0	0	0	0	0
194.05 07955	VACANT SPACE	0	0	0	0	0
194.06 07956	OLD AMBULANCE CENTER	10,816	0	0	0	10,816
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)	24,783,601	647,483	569,592	3,530,228	24,783,601

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151335

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

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	4,854,871					5.00
7.00	00700	528,293	2,696,878				7.00
8.00	00800	25,724	70,588	201,905			8.00
9.00	00900	121,657	65,575	2,145	688,766		9.00
10.00	01000	61,560	56,079	1,186	15,084	386,604	10.00
11.00	01100	108,472	145,006	0	39,003	0	11.00
13.00	01300	67,729	32,787	0	8,819	0	13.00
14.00	01400	50,994	82,651	0	22,231	0	14.00
15.00	01500	332,751	51,474	0	13,845	0	15.00
16.00	01600	340,209	149,815	0	40,296	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	675,138	261,871	86,191	70,436	385,771	30.00
31.00	03100	10,831	10,515	3,103	2,828	833	31.00
43.00	04300	73,707	15,303	4,107	4,116	0	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	345,294	385,583	32,624	103,713	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	160,638	210,764	8,396	56,690	0	52.00
53.00	05300	1,729	7,682	0	2,066	0	53.00
54.00	05400	352,035	187,819	12,776	50,518	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	49,143	13,327	776	3,585	0	59.00
60.00	06000	426,419	147,492	0	39,672	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	140,220	46,196	0	12,425	0	65.00
66.00	06600	83,566	73,665	4,517	19,814	0	66.00
67.00	06700	11,533	7,132	456	1,918	0	67.00
68.00	06800	2,944	1,447	91	389	0	68.00
69.00	06900	85,672	57,852	2,555	15,561	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	126,511	0	0	0	0	71.00
72.00	07200	31,079	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	11,236	30,057	0	8,084	0	75.01
76.97	07697	23,588	27,367	0	7,361	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	455,073	120,349	42,982	32,371	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		4,703,745	2,258,396	201,905	570,825	386,604	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	994	12,736	0	3,426	0	190.00
192.00	19200	29,571	379,021	0	101,947	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	56,640	6,684	0	1,798	0	194.00
194.01	07951	11,157	4,116	0	1,107	0	194.01
194.02	07952	50,129	35,925	0	9,663	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	2,635	0	0	0	0	194.06
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		4,854,871	2,696,878	201,905	688,766	386,604	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151335

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

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	737,745					11.00
13.00	01300	11,911	399,268				13.00
14.00	01400	17,351	0	382,552			14.00
15.00	01500	25,714	0	1,005	1,790,695		15.00
16.00	01600	111,342	0	0	0	2,038,182	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	193,331	195,376	44,760	0	129,057	30.00
31.00	03100	2,304	2,328	336	0	1,001	31.00
43.00	04300	16,521	16,696	0	0	16,994	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	68,677	69,402	97,998	0	433,456	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	32,857	33,204	0	0	34,268	52.00
53.00	05300	0	0	0	0	19,721	53.00
54.00	05400	70,670	0	4,139	0	567,199	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	4,655	0	0	0	6,085	59.00
60.00	06000	0	0	482	0	381,899	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	29,415	0	562	0	35,867	65.00
66.00	06600	19,056	0	1,433	0	46,327	66.00
67.00	06700	2,563	0	203	0	4,449	67.00
68.00	06800	246	0	0	0	915	68.00
69.00	06900	19,283	0	1,674	0	76,818	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	206,287	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	1,790,695	0	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	2,405	0	595	0	11,292	75.01
76.97	07697	6,113	0	122	0	6,718	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	81,402	82,262	20,957	0	266,116	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		715,816	399,268	380,553	1,790,695	2,038,182	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	2,630	0	0	0	0	194.00
194.01	07951	4,249	0	0	0	0	194.01
194.02	07952	15,050	0	1,999	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
200.00							200.00
201.00							201.00
202.00		737,745	399,268	382,552	1,790,695	2,038,182	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151335

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

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,813,326	0	4,813,326
31.00	03100	INTENSIVE CARE UNIT	78,540	0	78,540
43.00	04300	NURSERY	450,001	0	450,001
44.00	04400	SKILLED NURSING FACILITY	0	0	0
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,954,141	0	2,954,141
51.00	05100	RECOVERY ROOM	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,196,220	0	1,196,220
53.00	05300	ANESTHESIOLOGY	38,296	0	38,296
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,690,219	0	2,690,219
57.00	05700	CT SCAN	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	279,297	0	279,297
60.00	06000	LABORATORY	2,746,367	0	2,746,367
64.00	06400	INTRAVENOUS THERAPY	0	0	0
65.00	06500	RESPIRATORY THERAPY	840,273	0	840,273
66.00	06600	PHYSICAL THERAPY	591,409	0	591,409
67.00	06700	OCCUPATIONAL THERAPY	75,597	0	75,597
68.00	06800	SPEECH PATHOLOGY	18,115	0	18,115
69.00	06900	ELECTROCARDIOLOGY	611,087	0	611,087
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	852,110	0	852,110
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	158,655	0	158,655
73.00	07300	DRUGS CHARGED TO PATIENTS	1,790,695	0	1,790,695
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0
75.01	07501	SLEEP DISORDER	109,791	0	109,791
76.97	07697	CARDIAC REHABILITATION	168,097	0	168,097
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	2,969,535	0	2,969,535
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,431,771	0	23,431,771
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,235	0	21,235
192.00	19200	PHYSICIANS' PRIVATE OFFICES	631,924	0	631,924
193.00	19300	NONPAID WORKERS	0	0	0
194.00	07950	MARKETING	300,254	0	300,254
194.01	07951	FOUNDATION	66,428	0	66,428
194.02	07952	COMMUNITY OUTREACH	318,538	0	318,538
194.03	07953	WIC	0	0	0
194.04	07954	GRANTS	0	0	0
194.05	07955	VACANT SPACE	0	0	0
194.06	07956	OLD AMBULANCE CENTER	13,451	0	13,451
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118-201)	24,783,601	0	24,783,601

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	7	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	9	SQUARE FEET	9.00
10.00	DIETARY	10	PATIENT DAYS	10.00
11.00	CAFETERIA	11	PAID HOURS	11.00
13.00	NURSING ADMINISTRATION	13	PAID HOURS	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	GROSS CHARGES	16.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151335

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

Worksheet B
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL	407,580	100,429	88,348	596,357	6,534 5.00
7.00 00700	OPERATION OF PLANT	9,146	71,739	63,109	143,994	1,191 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	12,027	10,580	22,607	0 8.00
9.00 00900	HOUSEKEEPING	0	11,172	9,828	21,000	0 9.00
10.00 01000	DIETARY	0	9,555	8,405	17,960	0 10.00
11.00 01100	CAFETERIA	0	24,706	21,734	46,440	0 11.00
13.00 01300	NURSING ADMINISTRATION	0	5,586	4,914	10,500	756 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,600	14,082	12,388	28,070	596 14.00
15.00 01500	PHARMACY	0	8,770	7,715	16,485	1,779 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	6,889	25,525	22,455	54,869	3,206 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	12,961	44,617	39,250	96,828	8,620 30.00
31.00 03100	INTENSIVE CARE UNIT	848	1,791	1,576	4,215	130 31.00
43.00 04300	NURSERY	0	2,607	2,294	4,901	880 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	96,028	65,695	57,792	219,515	3,297 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	35,910	31,590	67,500	1,750 52.00
53.00 05300	ANESTHESIOLOGY	0	1,309	1,151	2,460	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	271,546	32,000	28,151	331,697	3,304 54.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	2,271	1,997	4,268	268 59.00
60.00 06000	LABORATORY	0	25,129	22,106	47,235	0 60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	7,892	7,871	6,924	22,687	1,772 65.00
66.00 06600	PHYSICAL THERAPY	467	12,551	11,041	24,059	981 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	1,215	1,069	2,284	140 67.00
68.00 06800	SPEECH PATHOLOGY	0	247	217	464	37 68.00
69.00 06900	ELECTROCARDIOLOGY	14,000	9,857	8,671	32,528	1,053 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
75.01 07501	SLEEP DISORDER	40	5,121	4,505	9,666	113 75.01
76.97 07697	CARDIAC REHABILITATION	0	4,663	4,102	8,765	283 76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	1,600	20,505	18,038	40,143	3,753 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	830,597	578,896	509,256	1,918,749	40,443 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,170	1,909	4,079	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	64,577	56,808	121,385	0 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	MARKETING	0	1,139	1,002	2,141	61 194.00
194.01 07951	FOUNDATION	0	701	617	1,318	144 194.01
194.02 07952	COMMUNITY OUTREACH	0	0	0	0	604 194.02
194.03 07953	WIC	0	0	0	0	0 194.03
194.04 07954	GRANTS	0	0	0	0	0 194.04
194.05 07955	VACANT SPACE	0	0	0	0	0 194.05
194.06 07956	OLD AMBULANCE CENTER	10,744	0	0	10,744	0 194.06
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)	841,341	647,483	569,592	2,058,416	41,252 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151335

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

Worksheet B
Part II
Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	602,891					5.00
7.00	00700	65,604	210,789				7.00
8.00	00800	3,194	5,517	31,318			8.00
9.00	00900	15,108	5,125	333	41,566		9.00
10.00	01000	7,645	4,383	184	910	31,082	10.00
11.00	01100	13,470	11,334	0	2,354	0	11.00
13.00	01300	8,411	2,563	0	532	0	13.00
14.00	01400	6,332	6,460	0	1,342	0	14.00
15.00	01500	41,321	4,023	0	836	0	15.00
16.00	01600	42,248	11,710	0	2,432	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	83,848	20,468	13,370	4,251	31,015	30.00
31.00	03100	1,345	822	481	171	67	31.00
43.00	04300	9,153	1,196	637	248	0	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	42,879	30,138	5,060	6,258	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	19,948	16,473	1,302	3,421	0	52.00
53.00	05300	215	600	0	125	0	53.00
54.00	05400	43,716	14,680	1,982	3,049	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	6,103	1,042	120	216	0	59.00
60.00	06000	52,953	11,528	0	2,394	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	17,413	3,611	0	750	0	65.00
66.00	06600	10,377	5,758	701	1,196	0	66.00
67.00	06700	1,432	557	71	116	0	67.00
68.00	06800	366	113	14	23	0	68.00
69.00	06900	10,639	4,522	396	939	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	15,710	0	0	0	0	71.00
72.00	07200	3,859	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	1,395	2,349	0	488	0	75.01
76.97	07697	2,929	2,139	0	444	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	56,511	9,407	6,667	1,954	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		584,124	176,518	31,318	34,449	31,082	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	123	995	0	207	0	190.00
192.00	19200	3,672	29,624	0	6,152	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	7,034	522	0	108	0	194.00
194.01	07951	1,386	322	0	67	0	194.01
194.02	07952	6,225	2,808	0	583	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	327	0	0	0	0	194.06
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		602,891	210,789	31,318	41,566	31,082	202.00

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	73,598					11.00
13.00	01300		23,950				13.00
14.00	01400	1,731		44,531			14.00
15.00	01500	2,565		117	67,126		15.00
16.00	01600	11,108		0	0	125,573	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	19,287	11,719	5,210	0	7,952	30.00
31.00	03100	230	140	39	0	62	31.00
43.00	04300	1,648	1,002	0	0	1,047	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,851	4,163	11,407	0	26,709	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	3,278	1,992	0	0	2,112	52.00
53.00	05300	0	0	0	0	1,215	53.00
54.00	05400	7,050	0	482	0	34,933	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	464	0	0	0	375	59.00
60.00	06000	0	0	56	0	23,532	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	2,934	0	65	0	2,210	65.00
66.00	06600	1,901	0	167	0	2,855	66.00
67.00	06700	256	0	24	0	274	67.00
68.00	06800	25	0	0	0	56	68.00
69.00	06900	1,924	0	195	0	4,733	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	24,013	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	67,126	0	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	240	0	69	0	696	75.01
76.97	07697	610	0	14	0	414	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	8,121	4,934	2,440	0	16,398	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		71,411	23,950	44,298	67,126	125,573	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	262	0	0	0	0	194.00
194.01	07951	424	0	0	0	0	194.01
194.02	07952	1,501	0	233	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		73,598	23,950	44,531	67,126	125,573	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151335

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

Worksheet B
Part II
Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	302,568	0	302,568
31.00	03100	INTENSIVE CARE UNIT	7,702	0	7,702
43.00	04300	NURSERY	20,712	0	20,712
44.00	04400	SKILLED NURSING FACILITY	0	0	0
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	356,277	0	356,277
51.00	05100	RECOVERY ROOM	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	117,776	0	117,776
53.00	05300	ANESTHESIOLOGY	4,615	0	4,615
54.00	05400	RADIOLOGY-DIAGNOSTIC	440,893	0	440,893
57.00	05700	CT SCAN	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	12,856	0	12,856
60.00	06000	LABORATORY	137,698	0	137,698
64.00	06400	INTRAVENOUS THERAPY	0	0	0
65.00	06500	RESPIRATORY THERAPY	51,442	0	51,442
66.00	06600	PHYSICAL THERAPY	47,995	0	47,995
67.00	06700	OCCUPATIONAL THERAPY	5,154	0	5,154
68.00	06800	SPEECH PATHOLOGY	1,098	0	1,098
69.00	06900	ELECTROCARDIOLOGY	56,929	0	56,929
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,723	0	39,723
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,859	0	3,859
73.00	07300	DRUGS CHARGED TO PATIENTS	67,126	0	67,126
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0
75.01	07501	SLEEP DISORDER	15,016	0	15,016
76.97	07697	CARDIAC REHABILITATION	15,598	0	15,598
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	150,328	0	150,328
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,855,365	0	1,855,365
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,404	0	5,404
192.00	19200	PHYSICIANS' PRIVATE OFFICES	160,833	0	160,833
193.00	19300	NONPAID WORKERS	0	0	0
194.00	07950	MARKETING	10,128	0	10,128
194.01	07951	FOUNDATION	3,661	0	3,661
194.02	07952	COMMUNITY OUTREACH	11,954	0	11,954
194.03	07953	WIC	0	0	0
194.04	07954	GRANTS	0	0	0
194.05	07955	VACANT SPACE	0	0	0
194.06	07956	OLD AMBULANCE CENTER	11,071	0	11,071
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118-201)	2,058,416	0	2,058,416

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	186,494			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		186,494		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,321	6,321	9,050,774	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,927	28,927	1,433,633	5.00
7.00	00700	OPERATION OF PLANT	20,663	20,663	261,218	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,464	3,464	0	8.00
9.00	00900	HOUSEKEEPING	3,218	3,218	0	9.00
10.00	01000	DIETARY	2,752	2,752	0	10.00
11.00	01100	CAFETERIA	7,116	7,116	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,609	1,609	165,827	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,056	4,056	130,674	14.00
15.00	01500	PHARMACY	2,526	2,526	390,355	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,352	7,352	703,424	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,851	12,851	1,891,580	30.00
31.00	03100	INTENSIVE CARE UNIT	516	516	28,558	31.00
43.00	04300	NURSERY	751	751	193,023	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,922	18,922	723,317	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,343	10,343	383,835	52.00
53.00	05300	ANESTHESIOLOGY	377	377	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,217	9,217	724,844	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	654	654	58,875	59.00
60.00	06000	LABORATORY	7,238	7,238	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,267	2,267	388,682	65.00
66.00	06600	PHYSICAL THERAPY	3,615	3,615	215,231	66.00
67.00	06700	OCCUPATIONAL THERAPY	350	350	30,673	67.00
68.00	06800	SPEECH PATHOLOGY	71	71	8,138	68.00
69.00	06900	ELECTROCARDIOLOGY	2,839	2,839	230,968	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501	SLEEP DISORDER	1,475	1,475	24,835	75.01
76.97	07697	CARDIAC REHABILITATION	1,343	1,343	62,005	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,906	5,906	823,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)		166,739	166,739	8,873,086	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	625	625	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,600	18,600	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	MARKETING	328	328	13,477	194.00
194.01	07951	FOUNDATION	202	202	31,605	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	132,606	194.02
194.03	07953	WIC	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	194.06
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)		647,483	569,592	3,530,228	202.00
203.00	Unit cost multiplier (wkst. B, Part I)		3.471870	3.054211	0.390047	203.00
204.00	Cost to be allocated (per wkst. B, Part II)				41,252	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151335

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

Worksheet B-1

Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description	CAPITAL RELATED COSTS			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQARE FEET)	MVBLE EQUIP (SQARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)			
	1.00	2.00	4.00			
205.00	Unit cost multiplier (wkst. B, Part II)			5A	5.00	205.00
			0.004558		0.030252	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151335

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

Worksheet B-1

Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		OPERATION OF PLANT (SQURE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQURE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (PAID HOURS)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	132,346				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,464	4,425			8.00
9.00	00900	HOUSEKEEPING	3,218	47	125,664		9.00
10.00	01000	DIETARY	2,752	26	2,752	3,249	10.00
11.00	01100	CAFETERIA	7,116	0	7,116	0	285,294
13.00	01300	NURSING ADMINISTRATION	1,609	0	1,609	0	4,606
14.00	01400	CENTRAL SERVICES & SUPPLY	4,056	0	4,056	0	6,710
15.00	01500	PHARMACY	2,526	0	2,526	0	9,944
16.00	01600	MEDICAL RECORDS & LIBRARY	7,352	0	7,352	0	43,057
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,851	1,889	12,851	3,242	74,764
31.00	03100	INTENSIVE CARE UNIT	516	68	516	7	891
43.00	04300	NURSERY	751	90	751	0	6,389
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,922	715	18,922	0	26,558
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,343	184	10,343	0	12,706
53.00	05300	ANESTHESIOLOGY	377	0	377	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,217	280	9,217	0	27,329
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	654	17	654	0	1,800
60.00	06000	LABORATORY	7,238	0	7,238	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,267	0	2,267	0	11,375
66.00	06600	PHYSICAL THERAPY	3,615	99	3,615	0	7,369
67.00	06700	OCCUPATIONAL THERAPY	350	10	350	0	991
68.00	06800	SPEECH PATHOLOGY	71	2	71	0	95
69.00	06900	ELECTROCARDIOLOGY	2,839	56	2,839	0	7,457
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	07501	SLEEP DISORDER	1,475	0	1,475	0	930
76.97	07697	CARDIAC REHABILITATION	1,343	0	1,343	0	2,364
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,906	942	5,906	0	31,479
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	110,828	4,425	104,146	3,249	276,814
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	625	0	625	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,600	0	18,600	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	MARKETING	328	0	328	0	1,017
194.01	07951	FOUNDATION	202	0	202	0	1,643
194.02	07952	COMMUNITY OUTREACH	1,763	0	1,763	0	5,820
194.03	07953	WIC	0	0	0	0	0
194.04	07954	GRANTS	0	0	0	0	0
194.05	07955	VACANT SPACE	0	0	0	0	0
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per wkst. B, Part I)	2,696,878	201,905	688,766	386,604	737,745
203.00		Unit cost multiplier (wkst. B, Part I)	20.377480	45.628249	5.481013	118.991690	2.585911
204.00		Cost to be allocated (per wkst. B, Part II)	210,789	31,318	41,566	31,082	73,598
205.00		Unit cost multiplier (wkst. B, Part II)	1.592712	7.077514	0.330771	9.566636	0.257972

Cost Center Description		NURSING ADMINISTRATION (PAID HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	152,787				13.00
14.00	01400	0	534,562			14.00
15.00	01500	0	1,404	10,000		15.00
16.00	01600	0	0	0	48,734,653	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	74,764	62,546	0	3,085,858	30.00
31.00	03100	891	470	0	23,938	31.00
43.00	04300	6,389	0	0	406,336	43.00
44.00	04400	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	26,558	136,938	0	10,364,302	50.00
51.00	05100	0	0	0	0	51.00
52.00	05200	12,706	0	0	819,384	52.00
53.00	05300	0	0	0	471,543	53.00
54.00	05400	0	5,783	0	13,562,184	54.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
59.00	05900	0	0	0	145,504	59.00
60.00	06000	0	673	0	9,131,535	60.00
64.00	06400	0	0	0	0	64.00
65.00	06500	0	785	0	857,602	65.00
66.00	06600	0	2,003	0	1,107,718	66.00
67.00	06700	0	284	0	106,368	67.00
68.00	06800	0	0	0	21,887	68.00
69.00	06900	0	2,339	0	1,836,785	69.00
70.00	07000	0	0	0	0	70.00
71.00	07100	0	288,257	0	0	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	0	10,000	0	73.00
75.00	07500	0	0	0	0	75.00
75.01	07501	0	832	0	270,003	75.01
76.97	07697	0	170	0	160,638	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	31,479	29,285	0	6,363,068	91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	0	0	0	0	95.00
101.00	10100	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00		152,787	531,769	10,000	48,734,653	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
193.00	19300	0	0	0	0	193.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	2,793	0	0	194.02
194.03	07953	0	0	0	0	194.03
194.04	07954	0	0	0	0	194.04
194.05	07955	0	0	0	0	194.05
194.06	07956	0	0	0	0	194.06
200.00						200.00
201.00						201.00
202.00		399,268	382,552	1,790,695	2,038,182	202.00
203.00		2.613233	0.715636	179.069500	0.041822	203.00
204.00		23,950	44,531	67,126	125,573	204.00
205.00		0.156754	0.083304	6.712600	0.002577	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151335

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		Cost
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,813,326		4,813,326	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	78,540		78,540	0	0	31.00
43.00	04300	NURSERY	450,001		450,001	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,954,141		2,954,141	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,196,220		1,196,220	0	0	52.00
53.00	05300	ANESTHESIOLOGY	38,296		38,296	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,690,219		2,690,219	0	0	54.00
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	279,297		279,297	0	0	59.00
60.00	06000	LABORATORY	2,746,367		2,746,367	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	840,273	0	840,273	0	0	65.00
66.00	06600	PHYSICAL THERAPY	591,409	0	591,409	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	75,597	0	75,597	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,115	0	18,115	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	611,087		611,087	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	852,110		852,110	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	158,655		158,655	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,790,695		1,790,695	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	SLEEP DISORDER	109,791		109,791	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	168,097		168,097	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	2,969,535		2,969,535	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	774,212		774,212	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
200.00		Subtotal (see instructions)	24,205,983	0	24,205,983	0	0	200.00
201.00		Less Observation Beds	774,212		774,212	0	0	201.00
202.00		Total (see instructions)	23,431,771	0	23,431,771	0	0	202.00

			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			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,511,212		2,511,212		30.00
31.00	03100	INTENSIVE CARE UNIT	23,938		23,938		31.00
43.00	04300	NURSERY	406,336		406,336		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,982,769	8,381,533	10,364,302	0.285030	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	819,020	364	819,384	1.459902	52.00
53.00	05300	ANESTHESIOLOGY	57,051	414,492	471,543	0.081214	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	807,820	12,754,365	13,562,185	0.198362	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	65,402	80,102	145,504	1.919514	59.00
60.00	06000	LABORATORY	1,105,810	8,025,725	9,131,535	0.300756	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	482,535	375,068	857,603	0.979793	65.00
66.00	06600	PHYSICAL THERAPY	179,348	928,370	1,107,718	0.533899	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,615	82,753	106,368	0.710712	67.00
68.00	06800	SPEECH PATHOLOGY	9,752	12,135	21,887	0.827660	68.00
69.00	06900	ELECTROCARDIOLOGY	436,083	1,400,702	1,836,785	0.332694	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,061,226	2,239,893	3,301,119	0.258128	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	208,638	451,471	660,109	0.240347	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,747,533	1,586,445	3,333,978	0.537105	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
75.01	07501	SLEEP DISORDER	0	270,003	270,003	0.406629	75.01
76.97	07697	CARDIAC REHABILITATION	0	160,638	160,638	1.046434	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	230,457	6,132,611	6,363,068	0.466683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	574,646	574,646	1.347285	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0.000000	101.00
200.00		Subtotal (see instructions)	12,158,545	43,871,316	56,029,861		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	12,158,545	43,871,316	56,029,861		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151335

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
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
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
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000			75.00
75.01	07501 SLEEP DISORDER	0.000000			75.01
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
101.00	10100 HOME HEALTH AGENCY				101.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,813,326		4,813,326	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	78,540		78,540	0	0	31.00
43.00	04300	NURSERY	450,001		450,001	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,954,141		2,954,141	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,196,220		1,196,220	0	0	52.00
53.00	05300	ANESTHESIOLOGY	38,296		38,296	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,690,219		2,690,219	0	0	54.00
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	279,297		279,297	0	0	59.00
60.00	06000	LABORATORY	2,746,367		2,746,367	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	840,273	0	840,273	0	0	65.00
66.00	06600	PHYSICAL THERAPY	591,409	0	591,409	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	75,597	0	75,597	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,115	0	18,115	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	611,087		611,087	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	852,110		852,110	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	158,655		158,655	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,790,695		1,790,695	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	SLEEP DISORDER	109,791		109,791	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	168,097		168,097	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	2,969,535		2,969,535	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	774,212		774,212	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
200.00		Subtotal (see instructions)	24,205,983	0	24,205,983	0	0	200.00
201.00		Less Observation Beds	774,212		774,212	0	0	201.00
202.00		Total (see instructions)	23,431,771	0	23,431,771	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 151335		Period: From 07/01/2012 To 06/30/2013		Worksheet C Part I Date/Time Prepared: 11/26/2013 1:17 pm	
			Title XIX		Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,511,212		2,511,212			30.00
31.00	03100	INTENSIVE CARE UNIT	23,938		23,938			31.00
43.00	04300	NURSERY	406,336		406,336			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,982,769	8,381,533	10,364,302	0.285030	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	819,020	364	819,384	1.459902	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	57,051	414,492	471,543	0.081214	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	807,820	12,754,365	13,562,185	0.198362	0.000000	54.00
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	65,402	80,102	145,504	1.919514	0.000000	59.00
60.00	06000	LABORATORY	1,105,810	8,025,725	9,131,535	0.300756	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	482,535	375,068	857,603	0.979793	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	179,348	928,370	1,107,718	0.533899	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,615	82,753	106,368	0.710712	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	9,752	12,135	21,887	0.827660	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	436,083	1,400,702	1,836,785	0.332694	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,061,226	2,239,893	3,301,119	0.258128	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	208,638	451,471	660,109	0.240347	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,747,533	1,586,445	3,333,978	0.537105	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	SLEEP DISORDER	0	270,003	270,003	0.406629	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	0	160,638	160,638	1.046434	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	230,457	6,132,611	6,363,068	0.466683	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	574,646	574,646	1.347285	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	12,158,545	43,871,316	56,029,861			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,158,545	43,871,316	56,029,861			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151335

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
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
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
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501	SLEEP DISORDER	0.000000		75.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151335

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

Worksheet D
Part II
Date/Time Prepared:
11/26/2013 1:17 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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	356,277	10,364,302	0.034375	441,367	15,172	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	117,776	819,384	0.143737	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,615	471,543	0.009787	14,387	141	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	440,893	13,562,185	0.032509	415,752	13,516	54.00
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	12,856	145,504	0.088355	9,400	831	59.00
60.00	06000	LABORATORY	137,698	9,131,535	0.015079	556,510	8,392	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	51,442	857,603	0.059983	198,226	11,890	65.00
66.00	06600	PHYSICAL THERAPY	47,995	1,107,718	0.043328	75,993	3,293	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,154	106,368	0.048454	5,969	289	67.00
68.00	06800	SPEECH PATHOLOGY	1,098	21,887	0.050167	4,178	210	68.00
69.00	06900	ELECTROCARDIOLOGY	56,929	1,836,785	0.030994	406,337	12,594	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,723	3,301,119	0.012033	533,814	6,423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,859	660,109	0.005846	108,317	633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	67,126	3,333,978	0.020134	923,565	18,595	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	15,016	270,003	0.055614	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	15,598	160,638	0.097100	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	150,328	6,363,068	0.023625	620	15	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	574,646	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,524,383	53,088,375		3,694,435	91,994	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		Title XVIII			Hospital		
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
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
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
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		Title XVIII			Hospital			
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	10,364,302	0.000000	0.000000	441,367	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	819,384	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	471,543	0.000000	0.000000	14,387	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,562,185	0.000000	0.000000	415,752	54.00
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	145,504	0.000000	0.000000	9,400	59.00
60.00	06000	LABORATORY	0	9,131,535	0.000000	0.000000	556,510	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	857,603	0.000000	0.000000	198,226	65.00
66.00	06600	PHYSICAL THERAPY	0	1,107,718	0.000000	0.000000	75,993	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	106,368	0.000000	0.000000	5,969	67.00
68.00	06800	SPEECH PATHOLOGY	0	21,887	0.000000	0.000000	4,178	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,836,785	0.000000	0.000000	406,337	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,301,119	0.000000	0.000000	533,814	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	660,109	0.000000	0.000000	108,317	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,333,978	0.000000	0.000000	923,565	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	SLEEP DISORDER	0	270,003	0.000000	0.000000	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	160,638	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	6,363,068	0.000000	0.000000	620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	574,646	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	53,088,375			3,694,435	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D Part IV Date/Time Prepared: 11/26/2013 1:17 pm

Cost Center Description		Title XVIII			Hospital		
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
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
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
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
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
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
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
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
75.00	07500 ASC (NON-DISTINCT PART)	0	0			75.00
75.01	07501 SLEEP DISORDER	0	0			75.01
76.97	07697 CARDIAC REHABILITATION	0	0			76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151335

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

Worksheet D
Part V
Date/Time Prepared:
11/26/2013 1:17 pm

		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.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.285030	0	2,721,589	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.459902	0	364	0	52.00
53.00	05300	ANESTHESIOLOGY	0.081214	0	160,498	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198362	0	3,835,526	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.919514	0	49,036	0	59.00
60.00	06000	LABORATORY	0.300756	0	2,652,548	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.979793	0	41,523	0	65.00
66.00	06600	PHYSICAL THERAPY	0.533899	0	294,308	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.710712	0	28,428	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.827660	0	2,803	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.332694	0	692,924	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.258128	0	847,310	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.240347	0	210,853	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.537105	0	574,529	3,574	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0.406629	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	1.046434	0	102,715	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.466683	0	1,777,193	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.347285	0	288,754	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	95.00
200.00		Subtotal (see instructions)		0	14,280,901	3,574	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	14,280,901	3,574	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151335	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/26/2013 1:17 pm
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		Title XVIII		Hospital	Cost
Cost Center Description		Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	775,735	0		50.00
51.00	05100 RECOVERY ROOM	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	531	0		52.00
53.00	05300 ANESTHESIOLOGY	13,035	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	760,823	0		54.00
57.00	05700 CT SCAN	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	94,125	0		59.00
60.00	06000 LABORATORY	797,770	0		60.00
64.00	06400 INTRAVENOUS THERAPY	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	40,684	0		65.00
66.00	06600 PHYSICAL THERAPY	157,131	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	20,204	0		67.00
68.00	06800 SPEECH PATHOLOGY	2,320	0		68.00
69.00	06900 ELECTROCARDIOLOGY	230,532	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	218,714	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	50,678	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	308,582	1,920		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501 SLEEP DISORDER	0	0		75.01
76.97	07697 CARDIAC REHABILITATION	107,484	0		76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	829,386	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	389,034	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	0		95.00
200.00	Subtotal (see instructions)	4,796,768	1,920		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00	Net Charges (line 200 +/- line 201)	4,796,768	1,920		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151335 Component CCN: 15Z335	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/26/2013 1:17 pm
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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
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.285030	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.459902	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.081214	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.198362	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	1.919514	0	0	0	59.00
60.00	06000 LABORATORY	0.300756	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.979793	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.533899	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.710712	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.827660	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.332694	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.258128	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.240347	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.537105	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
75.01	07501 SLEEP DISORDER	0.406629	0	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	1.046434	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0.466683	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.347285	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	95.00
200.00	Subtotal (see instructions)		0	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	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151335

Period: From 07/01/2012

Worksheet D

Component CCN: 15Z335

To 06/30/2013

Part V
Date/Time Prepared:
11/26/2013 1:17 pm

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
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
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
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
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
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501 SLEEP DISORDER	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
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: 151335

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

Worksheet D
Part I
Date/Time Prepared:
11/26/2013 1:17 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)	Hospital Total Patient Days	Per Diem (col. 3 / col. 4)	Cost	
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	302,568	16,219	286,349	3,848	74.42	30.00	
31.00	INTENSIVE CARE UNIT	7,702		7,702	7	1,100.29	31.00	
43.00	NURSERY	20,712		20,712	520	39.83	43.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
200.00	Total (lines 30-199)	330,982		314,763	4,375		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	98	7,293					30.00
31.00	INTENSIVE CARE UNIT	0	0					31.00
43.00	NURSERY	38	1,514					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30-199)	136	8,807					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151335

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

Worksheet D
Part II
Date/Time Prepared:
11/26/2013 1:17 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)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	356,277	10,364,302	0.034375	813,973	27,980	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	117,776	819,384	0.143737	244,302	35,115	52.00
53.00	05300 ANESTHESIOLOGY	4,615	471,543	0.009787	19,743	193	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	440,893	13,562,185	0.032509	93,410	3,037	54.00
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	12,856	145,504	0.088355	0	0	59.00
60.00	06000 LABORATORY	137,698	9,131,535	0.015079	215,898	3,256	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	51,442	857,603	0.059983	144,580	8,672	65.00
66.00	06600 PHYSICAL THERAPY	47,995	1,107,718	0.043328	7,260	315	66.00
67.00	06700 OCCUPATIONAL THERAPY	5,154	106,368	0.048454	407	20	67.00
68.00	06800 SPEECH PATHOLOGY	1,098	21,887	0.050167	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	56,929	1,836,785	0.030994	26,245	813	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	39,723	3,301,119	0.012033	35,143	423	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,859	660,109	0.005846	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	67,126	3,333,978	0.020134	326,636	6,576	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501 SLEEP DISORDER	15,016	270,003	0.055614	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	15,598	160,638	0.097100	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	150,328	6,363,068	0.023625	63,164	1,492	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	574,646	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,524,383	53,088,375		1,990,761	87,892	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151335	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part III Date/Time Prepared: 11/26/2013 1:17 pm
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Cost Center Description	Title XIX			Hospital	Total Costs
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	(sum of cols. 1 through 3, minus col. 4)
	1.00	2.00	3.00	4.00	5.00

INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
200.00		Total (lines 30-199)	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	3,848	0.00	98	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7	0.00	0	0	31.00
43.00	04300	NURSERY	520	0.00	38	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	44.00
200.00		Total (lines 30-199)	4,375		136	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
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
200.00		Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description	Title XIX				Hospital	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
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
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
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D Part IV Date/Time Prepared: 11/26/2013 1:17 pm

Cost Center Description		Title XIX			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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	10,364,302	0.000000	0.000000	813,973	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	819,384	0.000000	0.000000	244,302	52.00
53.00	05300	ANESTHESIOLOGY	0	471,543	0.000000	0.000000	19,743	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,562,185	0.000000	0.000000	93,410	54.00
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	145,504	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	9,131,535	0.000000	0.000000	215,898	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	857,603	0.000000	0.000000	144,580	65.00
66.00	06600	PHYSICAL THERAPY	0	1,107,718	0.000000	0.000000	7,260	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	106,368	0.000000	0.000000	407	67.00
68.00	06800	SPEECH PATHOLOGY	0	21,887	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,836,785	0.000000	0.000000	26,245	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,301,119	0.000000	0.000000	35,143	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	660,109	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,333,978	0.000000	0.000000	326,636	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	SLEEP DISORDER	0	270,003	0.000000	0.000000	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	160,638	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	6,363,068	0.000000	0.000000	63,164	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	574,646	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0					95.00
200.00		Total (lines 50-199)	0	53,088,375			1,990,761	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151335	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/26/2013 1:17 pm
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Cost Center Description	Title XIX			Hospital		PSA Adj. Non Physician Anesthetist Cost	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			
ANCILLARY SERVICE COST CENTERS								
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
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
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
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: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
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
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
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
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
75.00	07500 ASC (NON-DISTINCT PART)	0	0			75.00
75.01	07501 SLEEP DISORDER	0	0			75.01
76.97	07697 CARDIAC REHABILITATION	0	0			76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0			200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151335	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/26/2013 1:17 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,099 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,848 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)			3,194 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			107 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)			107 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			19 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)			18 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,836 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)			107 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)			107 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			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)			4,813,326 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)			2,401 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)			2,274 25.00
26.00	Total swing-bed cost (see instructions)			258,010 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,555,316 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			4,555,316 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,183.81 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,173,475 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)			2,173,475 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151335

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

Worksheet D-1

Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description	Title XVIII			Hospital	Cost		
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	78,540	7	11,220.00	7	78,540		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,432,702		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,684,717		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					126,668		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					126,668		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					253,336		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					654		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,183.81		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					774,212		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151335

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

Worksheet D-1

Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Hospital		
				Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	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: 151335

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

Worksheet D-1

Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		Title XIX	Hospital	Cost	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,099	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,848	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)			3,194	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			107	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)			107	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			19	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)			18	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			98	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			7	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)			6	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)			520	15.00
16.00	Nursery days (title V or XIX only)			38	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				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)			4,813,326	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)			2,401	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)			2,274	25.00
26.00	Total swing-bed cost (see instructions)			258,010	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,555,316	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			4,555,316	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,183.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			116,013	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)			116,013	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151335

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

Worksheet D-1

Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		Title XIX			Hospital	Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	450,001	520	865.39	38	32,885	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	78,540	7	11,220.00	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							
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,042,271	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,191,169	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					885	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)					758	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					1,643	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					654	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,183.81	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					774,212	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151335

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

Worksheet D-1

Date/Time Prepared:
11/26/2013 1:17 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151335	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/26/2013 1:17 pm	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,058,729	30.00
31.00	03100	INTENSIVE CARE UNIT		7,358	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.285030	441,367	125,803 50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.459902	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.081214	14,387	1,168 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198362	415,752	82,469 54.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	1.919514	9,400	18,043 59.00
60.00	06000	LABORATORY	0.300756	556,510	167,374 60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.979793	198,226	194,220 65.00
66.00	06600	PHYSICAL THERAPY	0.533899	75,993	40,573 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.710712	5,969	4,242 67.00
68.00	06800	SPEECH PATHOLOGY	0.827660	4,178	3,458 68.00
69.00	06900	ELECTROCARDIOLOGY	0.332694	406,337	135,186 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.258128	533,814	137,792 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.240347	108,317	26,034 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.537105	923,565	496,051 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0 75.00
75.01	07501	SLEEP DISORDER	0.406629	0	0 75.01
76.97	07697	CARDIAC REHABILITATION	1.046434	0	0 76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.466683	620	289 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.347285	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		3,694,435	1,432,702 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		3,694,435	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151335 Component CCN: 152335	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/26/2013 1:17 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.285030	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.459902	0	52.00
53.00	05300	ANESTHESIOLOGY	0.081214	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198362	6,366	54.00
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	1.919514	0	59.00
60.00	06000	LABORATORY	0.300756	10,917	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.979793	5,618	65.00
66.00	06600	PHYSICAL THERAPY	0.533899	62,774	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.710712	12,250	67.00
68.00	06800	SPEECH PATHOLOGY	0.827660	4,771	68.00
69.00	06900	ELECTROCARDIOLOGY	0.332694	3,501	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.258128	18,402	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.240347	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.537105	64,302	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
75.01	07501	SLEEP DISORDER	0.406629	0	75.01
76.97	07697	CARDIAC REHABILITATION	1.046434	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.466683	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.347285	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		188,901	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)		188,901	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151335	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/26/2013 1:17 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		602,737	30.00
31.00	03100	INTENSIVE CARE UNIT		3,080	31.00
43.00	04300	NURSERY		322,487	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.285030	813,973	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.459902	244,302	52.00
53.00	05300	ANESTHESIOLOGY	0.081214	19,743	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198362	93,410	54.00
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	1.919514	0	59.00
60.00	06000	LABORATORY	0.300756	215,898	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.979793	144,580	65.00
66.00	06600	PHYSICAL THERAPY	0.533899	7,260	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.710712	407	67.00
68.00	06800	SPEECH PATHOLOGY	0.827660	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.332694	26,245	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.258128	35,143	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.240347	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.537105	326,636	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
75.01	07501	SLEEP DISORDER	0.406629	0	75.01
76.97	07697	CARDIAC REHABILITATION	1.046434	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.466683	63,164	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.347285	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,990,761	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)		1,990,761	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151335

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

Worksheet E
Part B
Date/Time Prepared:
11/26/2013 1:17 pm

		Title XVIII	Hospital	Cost	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			4,798,688	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)			4,798,688	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
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
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			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)			4,846,675	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
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance (for CAH, see instructions)			21,093	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,336,901	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)			2,488,681	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)			2,488,681	30.00
31.00	Primary payer payments			2,761	31.00
32.00	Subtotal (line 30 minus line 31)			2,485,920	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)					
33.00	Composite rate ESRD (from worksheet I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			497,778	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			497,778	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			425,889	36.00
37.00	Subtotal (see instructions)			2,983,698	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER			0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			2,983,698	40.00
40.01	Sequestration adjustment (see instructions)			14,918	40.01
41.00	Interim payments			3,209,596	41.00
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)			-240,816	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0	44.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00
				overrides	
				1.00	
WORKSHEET OVERRIDE VALUES					
112.00	Override of Ancillary service charges (line 12)			0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151335

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

Worksheet E-1
Part I
Date/Time Prepared:
11/26/2013 1:17 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		3,715,184		3,209,596	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	02/15/2013	190,400		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		190,400		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)		3,905,584		3,209,596	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		528,066		225,898	6.02	
7.00	Total Medicare program liability (see instructions)		3,377,518		2,983,698	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: 151335 Component CCN: 15Z335		Period: From 07/01/2012 To 06/30/2013		Worksheet E-1 Part I Date/Time Prepared: 11/26/2013 1:17 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		322,111		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
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or Wkst. E-3, line and column as appropriate)		322,111		0		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		29,952		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		352,063		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: 151335
Component CCN: 152335

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

Worksheet E-2
Date/Time Prepared:
11/26/2013 1:17 pm

Title XVIII		Swing Beds - SNF		Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	255,869	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from wkst. D-3, column 3, line 200 for Part A, and sum of wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	97,639	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	214	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	353,508	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	353,508	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	353,508	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,445	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	352,063	0	15.00
16.00	OTHER	0	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	352,063	0	19.00
19.01	Sequestration adjustment (see instructions)	1,760	0	19.01
20.00	Interim payments	322,111	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	28,192	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151335	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part V Date/Time Prepared: 11/26/2013 1:17 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		3,684,717	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)		3,684,717	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,721,564	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
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
Customary charges				
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
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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)		3,721,564	19.00
20.00	Deductibles (exclude professional component)		366,815	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		3,354,749	22.00
23.00	Coinsurance		4,440	23.00
24.00	Subtotal (line 22 minus line 23)		3,350,309	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		27,209	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		27,209	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		21,481	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		3,377,518	28.00
29.00	OTHER		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		3,377,518	30.00
30.01	Sequestration adjustment (see instructions)		16,888	30.01
31.00	Interim payments		3,905,584	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		-544,954	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: 151335	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2013 1:17 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		1,191,169		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,191,169	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,191,169	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		928,303		8.00
9.00	Ancillary service charges		1,990,761	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)		2,919,064	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		2,919,064	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,727,895	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)		1,191,169	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1,191,169	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,191,169	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinsurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1,191,169	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		1,191,169	0	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1,191,169	0	40.00
41.00	Interim payments		1,191,169	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		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: 151335

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

Worksheet G

Date/Time Prepared:
11/26/2013 1:17 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	1,771,162	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	7,494,970	0	0	0	4.00
5.00 Other receivable	1,072,210	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-5,238,752	0	0	0	6.00
7.00 Inventory	466,167	0	0	0	7.00
8.00 Prepaid expenses	104,655	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	-2,420	2,420	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	5,667,992	2,420	0	0	11.00
FIXED ASSETS					
12.00 Land	100,000	0	0	0	12.00
13.00 Land improvements	60,000	0	0	0	13.00
14.00 Accumulated depreciation	-18,000	0	0	0	14.00
15.00 Buildings	5,621,906	0	0	0	15.00
16.00 Accumulated depreciation	-827,756	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	1,413,708	0	0	0	19.00
20.00 Accumulated depreciation	-698,517	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	2,541,468	0	0	0	23.00
24.00 Accumulated depreciation	-1,949,365	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)	6,243,444	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	2,041,864	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	2,041,864	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	13,953,300	2,420	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	514,187	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,541,394	0	0	0	38.00
39.00 Payroll taxes payable	90,366	0	0	0	39.00
40.00 Notes and loans payable (short term)	112,565	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	2,021,931	0	0	0	43.00
44.00 Other current liabilities	2,725,562	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	7,006,005	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	7,707,360	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	7,707,360	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	14,713,365	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	-760,065				52.00
53.00 Specific purpose fund		2,420			53.00
54.00 Donor created - endowment fund balance - restricted			0		54.00
55.00 Donor created - endowment fund balance - unrestricted			0		55.00
56.00 Governing body created - endowment fund balance			0		56.00
57.00 Plant fund balance - invested in plant				0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	-760,065	2,420	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	13,953,300	2,420	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151335

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

Worksheet G-1

Date/Time Prepared:
11/26/2013 1:17 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		-2,104,103		31,125		1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		1,583,739				2.00
3.00	Total (sum of line 1 and line 2)		-520,364		31,125		3.00
4.00	RELEASED OPERATING	28,999		0		0	4.00
5.00	OTHER	0		2,420		0	5.00
6.00		0		0		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)		28,999		2,420		10.00
11.00	Subtotal (line 3 plus line 10)		-491,365		33,545		11.00
12.00	DEFERRED PENSION COST ADJUSTMENT	265,283		0		0	12.00
13.00	TRANSFER TO AFFILIATES	3,417		0		0	13.00
14.00	RELEASED OPERATING	0		2,126		0	14.00
15.00	RELEASED CAPITAL	0		28,999		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)		268,700		31,125		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-760,065		2,420		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	RELEASED OPERATING		0				4.00
5.00	OTHER		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	DEFERRED PENSION COST ADJUSTMENT		0				12.00
13.00	TRANSFER TO AFFILIATES		0				13.00
14.00	RELEASED OPERATING		0				14.00
15.00	RELEASED CAPITAL		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: 151335

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/26/2013 1:17 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,280,220		4,280,220	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	4,280,220		4,280,220	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	64,555		64,555	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)	64,555		64,555	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,344,775		4,344,775	17.00
18.00	Ancillary services	8,104,802	37,387,125	45,491,927	18.00
19.00	Outpatient services	230,644	6,145,062	6,375,706	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	0	0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	COMMUNITY OUTREACH	0	480,763	480,763	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	12,680,221	44,012,950	56,693,171	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		24,984,898		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		24,984,898		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151335

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

Worksheet G-3

Date/Time Prepared:
11/26/2013 1:17 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	56,693,171	1.00
2.00	Less contractual allowances and discounts on patients' accounts	31,382,407	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,310,764	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,984,898	4.00
5.00	Net income from service to patients (line 3 minus line 4)	325,866	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	948	6.00
7.00	Income from investments	63,650	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	87,370	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	16,862	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	67,251	22.00
23.00	Governmental appropriations	415,304	23.00
24.00	MISC	86,128	24.00
24.01	MISC DIETARY	909	24.01
24.02	MISC OTHER	384	24.02
24.03	BUILDING RENT	130,970	24.03
24.04	MEDICAID EHR	399,581	24.04
24.05		0	24.05
24.06		0	24.06
24.07		0	24.07
25.00	Total other income (sum of lines 6-24)	1,269,357	25.00
26.00	Total (line 5 plus line 25)	1,595,223	26.00
27.00	UNREALIZED LOSS	9,821	27.00
27.01	LLOSS ON INTEREST RATE SWAP	1,663	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	11,484	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,583,739	29.00