

St. Vincent Salem Hospital

Provider No. 15-1314, 15-Z314, and Aim No. 200976990

**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: 151314	Period: From 07/01/2012 To 06/30/2013	Worksheet 5 Parts I-III Date/Time Prepared: 11/26/2013 1:37 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/26/2013 Time: 1:37 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN
		10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST VINCENT SALEM (151314) 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: 1:37 pm
gmFChNF8S53w:a8eWQozT3NDadpz40
R.iZK0AyAfn9SjkyQ6Lo7.kuh3ob.
Ufhb0L9i0B00bbyI
PI: Date: 11/26/2013 Time: 1:37 pm
JtMtxexyBBSU0WpHceog:3VlgClFY0
iE2yw0ODSWYif2zQuOp8YALywhav51
s.5f0bgPvN0lqBWL

(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	125,535	202,062	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	237,596	0	0	0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	363,131	202,062	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: 151314	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 9:45 am
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1.00	2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:								
1.00	Street: 911 N. SHELBY STREET			PO Box:			1.00	
2.00	City: SALEM		State: IN	Zip Code: 47167	County: WASHINGTON			2.00

	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 SALEM	151314	31140	1	12/01/2002	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 SALEM	152314	31140		12/01/2002	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:
20.00	Cost Reporting Period (mm/dd/yyyy)	1.00	2.00
21.00	Type of Control (see instructions)	07/01/2012	06/30/2013

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.		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	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	25.00

	Urban/Rural	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: 151314	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 9:45 am			
		Beginning: 1.00	Ending: 2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.		0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	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	XVIII	XIX			
		1.00	2.00	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	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	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	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	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: 151314

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

Worksheet S-2
Part I
Date/Time Prepared:
11/26/2013 9:45 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
		1.00	2.00	3.00	4.00			
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20		
						1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings								
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)					N	63.00	
				Unweighted FTEs 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	64.00	
				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	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	66.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151314	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 9:45 am			
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	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.				Y	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	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	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:	19,452	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: 08001		141.00	
142.00	Street: 10330 N. MERIDIAN STREET	PO Box:				142.00	
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290			143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.					N	145.00
						1.00	
						2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N	146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		
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	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
						1.00	
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	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00
						Beginning	Ending
						1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151314	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/26/2013 9:45 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N	2.00	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			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
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.			Y	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL		HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3519		JILL.HILL@STVINCENT.ORG	43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	10/02/2013		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.	MANAGER, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HFS Supplemental Information

Provider CCN: 151314

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

Worksheet S-2
Part IX
Date/Time Prepared:
11/26/2013 9:45 am

		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: 151314

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

Worksheet S-3
Part I
Date/Time Prepared:
11/26/2013 9:45 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	Title v
	Line Number				Visits / Trips	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	21,816.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	21,816.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	21,816.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25			0	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: 151314

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

Worksheet S-3
Part I
Date/Time Prepared:
11/26/2013 9:45 am

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)	514	33	909			1.00
2.00 HMO and other (see instructions)	165	27				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	341	0	341			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	124			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	855	33	1,374			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)	855	33	1,374	0.00	129.46	14.00
15.00 CAH visits	8,227	1,468	24,095			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	129.46	27.00
28.00 Observation Bed Days		0	384			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			13			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151314

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

Worksheet S-3
Part I
Date/Time Prepared:
11/26/2013 9:45 am

Component	Full Time	Discharges				Total All Patients	
	Equivalents	Title V	Title XVIII	Title XIX			
	Nonpaid Workers	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	168	27	315	1.00
2.00 HMO and other (see instructions)				54			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	168	27		315	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						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: 151314	Period: From 07/01/2012 To 06/30/2013	Worksheet S-10 Date/Time Prepared: 11/26/2013 9:45 am
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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)		0.352295	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		222,787	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		7,641,128	6.00	
7.00	Medicaid cost (line 1 times line 6)		2,691,931	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)		2,469,144	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		33,723	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,469,144	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		3,219,262	69,966	3,289,228
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		1,134,130	24,649	1,158,779
22.00	Partial payment by patients approved for charity care		0	0	0
23.00	Cost of charity care (line 21 minus line 22)		1,134,130	24,649	1,158,779
			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?				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)			1,382,497	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			476,665	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)			905,832	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			319,120	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			1,477,899	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,947,043	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151314

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

Worksheet A

Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (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		412,179	412,179	0	412,179	1.00
2.00	00200		0	0	0	0	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	130,913	1,985,478	2,116,391	0	2,116,391	4.00
5.00	00500	1,607,986	2,635,159	4,243,145	0	4,243,145	5.00
7.00	00700	157,466	1,420,218	1,577,684	0	1,577,684	7.00
8.00	00800	0	0	0	0	0	8.00
9.00	00900	0	296,600	296,600	0	296,600	9.00
10.00	01000	0	384,860	384,860	-318,132	66,728	10.00
11.00	01100	0	0	0	318,132	318,132	11.00
13.00	01300	57,789	8,917	66,706	0	66,706	13.00
14.00	01400	92,020	23,007	115,027	0	115,027	14.00
15.00	01500	203,166	84,926	288,092	0	288,092	15.00
16.00	01600	266,050	31,276	297,326	0	297,326	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	808,958	93,498	902,456	-1,102	901,354	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	602,734	482,970	1,085,704	-204,367	881,337	50.00
54.00	05400	635,450	339,312	974,762	-174	974,588	54.00
58.00	05800	46,829	189,527	236,356	0	236,356	58.00
60.00	06000	0	1,322,114	1,322,114	0	1,322,114	60.00
61.00	06100		0	0	0	0	61.00
65.00	06500	218,200	17,894	236,094	0	236,094	65.00
66.00	06600	404,552	18,038	422,590	-50,593	371,997	66.00
67.00	06700	0	106	106	50,258	50,364	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	126,513	7,033	133,546	0	133,546	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	8,627	8,627	208,651	217,278	71.00
72.00	07200	0	91,591	91,591	0	91,591	72.00
73.00	07300	0	239,004	239,004	0	239,004	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	03950	145,807	73,484	219,291	0	219,291	75.01
75.03	07501	0	392,397	392,397	0	392,397	75.03
76.97	07697	81,704	8,154	89,858	0	89,858	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	756,173	1,041,150	1,797,323	-2,673	1,794,650	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		6,342,310	11,607,519	17,949,829	0	17,949,829	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	74,553	4,439	78,992	0	78,992	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	56,666	4,362	61,028	0	61,028	193.01
193.02	19302	25,599	286	25,885	0	25,885	193.02
200.00		6,499,128	11,616,606	18,115,734	0	18,115,734	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151314

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

Worksheet A

Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
		0	412,179	
2.00	00200		0	2.00
		0	0	
3.00	00300		0	3.00
		0	0	
4.00	00400	-29,205	2,087,186	4.00
5.00	00500	48,546	4,291,691	5.00
7.00	00700	3,523	1,581,207	7.00
8.00	00800	0	0	8.00
9.00	00900	0	296,600	9.00
10.00	01000	0	66,728	10.00
11.00	01100	-65,782	252,350	11.00
13.00	01300	0	66,706	13.00
14.00	01400	0	115,027	14.00
15.00	01500	0	288,092	15.00
16.00	01600	-6,488	290,838	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	-47,000	854,354	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	0	881,337	50.00
54.00	05400	-150,966	823,622	54.00
58.00	05800	0	236,356	58.00
60.00	06000	0	1,322,114	60.00
61.00	06100	0	0	61.00
65.00	06500	0	236,094	65.00
66.00	06600	0	371,997	66.00
67.00	06700	0	50,364	67.00
68.00	06800	0	0	68.00
69.00	06900	0	133,546	69.00
70.00	07000	0	0	70.00
71.00	07100	0	217,278	71.00
72.00	07200	0	91,591	72.00
73.00	07300	0	239,004	73.00
74.00	07400	0	0	74.00
75.00	07500	0	0	75.00
75.01	03950	-51,600	167,691	75.01
75.03	07501	0	392,397	75.03
76.97	07697	0	89,858	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	0	0	88.00
89.00	08900	0	0	89.00
90.00	09000	0	0	90.00
91.00	09100	-150,000	1,644,650	91.00
92.00	09200	0	0	92.00
SPECIAL PURPOSE COST CENTERS				
118.00		-448,972	17,500,857	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	0	190.00
191.00	19100	0	0	191.00
192.00	19200	0	78,992	192.00
193.00	19300	0	0	193.00
193.01	19301	161,589	222,617	193.01
193.02	19302	0	25,885	193.02
200.00		-287,383	17,828,351	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 151314

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

Worksheet Non-CMS W

Date/Time Prepared:
11/26/2013 9:45 am

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
3.00	OTHER CAP RELATED COST	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
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
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
54.00	RADIOLOGY - DIAGNOSTIC	05400		54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
60.00	LABORATORY	06000		60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	06100		61.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
75.00	ASC (NON-DISTINCT PART)	07500		75.00
75.01	SLEEP DISORDER	03950		75.01
75.03	ADULT MENTAL HEALTH	07501		75.03
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
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
191.00	RESEARCH	19100		191.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
193.00	NONPAID WORKERS	19300		193.00
193.01	MARKETING/ PUBLIC RELATIONS	19301		193.01
193.02	NEW HORIZON OP	19302		193.02
200.00	TOTAL (SUM OF LINES 118-199)			200.00

Provider CCN: 151314

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

Worksheet A-6

Date/Time Prepared:
11/26/2013 9:45 am

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - CAFETERIA					
1.00	CAFETERIA	11.00	0	318,132	1.00
	TOTALS		0	318,132	
B - BILLABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	208,651	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	208,651	
C - PT / OT					
1.00	OCCUPATIONAL THERAPY	67.00	48,202	2,056	1.00
	TOTALS		48,202	2,056	
500.00	Grand Total: Increases		48,202	528,839	500.00

Provider CCN: 151314

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

Worksheet A-6
Date/Time Prepared:
11/26/2013 9:45 am

		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	318,132	0		1.00
	TOTALS		0	318,132			
B - BILLABLE MEDICAL SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	1,102	0		1.00
2.00	OPERATING ROOM	50.00	0	204,367	0		2.00
3.00	RADIOLOGY - DIAGNOSTIC	54.00	0	174	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	335	0		4.00
5.00	EMERGENCY	91.00	0	2,673	0		5.00
	TOTALS		0	208,651			
C - PT / OT							
1.00	PHYSICAL THERAPY	66.00	48,202	2,056	0		1.00
	TOTALS		48,202	2,056			
500.00	Grand Total: Decreases		48,202	528,839			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 - BILLABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	ADULTS & PEDIATRICS	30.00
2.00		0.00	0	OPERATING ROOM	50.00
3.00		0.00	0	RADIOLOGY - DIAGNOSTIC	54.00
4.00		0.00	0	PHYSICAL THERAPY	66.00
5.00		0.00	0	EMERGENCY	91.00
	TOTALS		0	TOTALS	0
C - PT / OT					
1.00	OCCUPATIONAL THERAPY	67.00	48,202	PHYSICAL THERAPY	66.00
	TOTALS		48,202	TOTALS	48,202
500.00	Grand Total: Increases		48,202	Grand Total: Decreases	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151314

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

Worksheet A-7
Part I
Date/Time Prepared:
11/26/2013 9:45 am

	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	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	159,641	0	159,641	3.00
4.00	Building Improvements	795,856	61,112	0	61,112	4.00
5.00	Fixed Equipment	495,809	7,998	0	7,998	5.00
6.00	Movable Equipment	310,097	42,309	0	42,309	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,601,762	271,060	0	271,060	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	1,601,762	271,060	0	271,060	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	159,641	0			3.00
4.00	Building Improvements	856,968	0			4.00
5.00	Fixed Equipment	503,807	0			5.00
6.00	Movable Equipment	352,406	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	1,872,822	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	1,872,822	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151314

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

Worksheet A-7
Part II
Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	389,637	0	22,542	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	389,637	0	22,542	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	412,179				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	412,179				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151314

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

Worksheet A-7
Part III
Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,872,822	0	1,872,822	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1,872,822	0	1,872,822	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	0	389,637	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	389,637	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	0	22,542	0	0	412,179	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	22,542	0	0	412,179	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)		0		0.00		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)		0		0.00		0	7.00
8.00 Television and radio service (chapter 21)		0		0.00		0	8.00
9.00 Parking lot (chapter 21)		0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-399,348				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	835,641				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-65,782	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	-23,567	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 DONATIONS AND CHARITABLE EXPENSES	A	-8,250	ADMINISTRATIVE & GENERAL	5.00		0	33.00

Provider CCN: 151314

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

Worksheet A-8

Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7	Ref.
			1.00	2.00	3.00	4.00
33.01 OTHER REVENUE - ADMINISTRATION	B	-4,983	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 ASSOCIATION DUES LOBBYING EXPENSE OF	A	-523	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 OTHER REVENUE - RADIOLOGY	B	-218	RADIOLOGY - DIAGNOSTIC	54.00	0	33.03
33.04 MED RECORDS FOR SPN	A	17,079	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05 DONATIONS AND CHARITABLE EXPENSES	A	-125	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06 PROVIDER TAX	A	-594,936	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 CABLE TV	A	-3,793	OPERATION OF PLANT	7.00	0	33.07
33.08 BIOTERRORISM GRANT	B	-30,838	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09 QUALITY REVIEW GRANT	B	-7,740	ADMINISTRATIVE & GENERAL	5.00	0	33.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-287,383				50.00

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

Provider CCN: 151314

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

Worksheet A-8-1

Date/Time Prepared: 11/26/2013 9:45 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	SVH - NON CAPITAL	2,069,513	1,196,664	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH - BENEFITS	79,660	79,660	2.00
3.00	193.01	MARKETING/ PUBLIC RELATIONS	SVH - MARKETING	161,589	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH - SELF INSURANCE	953,000	982,080	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	DIRECT CHARGEBACKS - BENEFITS	145,564	145,564	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	DIRECT CHARGEBACKS - A&G	683,285	683,285	4.02
4.03	13.00	NURSING ADMINISTRATION	DIRECT CHARGEBACKS - NURSING ADMIN	1,068	1,068	4.03
4.04	14.00	CENTRAL SERVICES & SUPPLY	DIRECT CHARGEBACKS - SUPPLY	90,294	90,294	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	DIRECT CHARGEBACKS - MED REC	31,803	31,803	4.05
4.06	54.00	RADIOLOGY - DIAGNOSTIC	DIRECT CHARGEBACKS - RADIOLOGY	5,925	5,925	4.06
4.07	91.00	EMERGENCY	DIRECT CHARGEBACKS - EMERGENCY	5	5	4.07
4.08	7.00	OPERATION OF PLANT	ASCENSION - TRIMEDX	513,791	506,475	4.08
4.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION - PENSION	272,059	272,059	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	SVH - HO OFFSET	0	177,033	4.10
4.11	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION PAYMENTS	22,542	22,542	4.11
4.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PAYMENTS	54,398	54,398	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	ASCENSION PAYMENTS	28,362	28,362	4.13
5.00	0			5,112,858	4,277,217	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	ASCENSION HEALT	100.00	ASCENSION HEALT	100.00	6.00
7.00	G	ST VINCENT HEAL	100.00	ST VINCENT HEAL	100.00	7.00
8.00	G	CATHOLIC HEALTH	100.00	CATHOLIC HEALTH	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: 151314

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

Worksheet A-8-1

Date/Time Prepared:
11/26/2013 9:45 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	872,849	0	1.00
2.00	0	9	2.00
3.00	161,589	0	3.00
4.00	-29,080	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
4.03	0	0	4.03
4.04	0	0	4.04
4.05	0	0	4.05
4.06	0	0	4.06
4.07	0	0	4.07
4.08	7,316	0	4.08
4.09	0	0	4.09
4.10	-177,033	0	4.10
4.11	0	9	4.11
4.12	0	0	4.12
4.13	0	0	4.13
5.00	835,641		5.00

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

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151314

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

Worksheet A-8-2

Date/Time Prepared:
11/26/2013 9:45 am

	wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	929,793	150,000	779,793	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	47,000	47,000	0	0	0	2.00
3.00	50.00	OPERATING ROOM	38,022	0	38,022	0	0	3.00
4.00	54.00	RADIOLOGY - DIAGNOSTIC	172,784	150,748	22,036	0	0	4.00
5.00	75.01	SLEEP DISORDER	51,600	51,600	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,239,199	399,348	839,851	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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	4.00
5.00	75.01	SLEEP DISORDER	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	150,000		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	47,000		2.00
3.00	50.00	OPERATING ROOM	0	0	0	0		3.00
4.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	150,748		4.00
5.00	75.01	SLEEP DISORDER	0	0	0	51,600		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	399,348		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151314

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

Worksheet B
Part I
Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	412,179	412,179			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,087,186	1,064	0	2,088,250	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,291,691	45,715	0	527,285	5.00
7.00 00700	OPERATION OF PLANT	1,581,207	51,121	0	51,636	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	296,600	16,697	0	0	9.00
10.00 01000	DIETARY	66,728	42,799	0	0	10.00
11.00 01100	CAFETERIA	252,350	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	66,706	5,654	0	18,950	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	115,027	13,268	0	30,175	14.00
15.00 01500	PHARMACY	288,092	5,393	0	66,622	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	290,838	12,691	0	87,243	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	854,354	39,280	0	265,272	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	881,337	40,838	0	197,647	50.00
54.00 05400	RADIOLOGY - DIAGNOSTIC	823,622	21,241	0	208,375	54.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	236,356	5,310	0	15,356	58.00
60.00 06000	LABORATORY	1,322,114	9,832	0	0	60.00
61.00 06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	61.00
65.00 06500	RESPIRATORY THERAPY	236,094	2,629	0	71,552	65.00
66.00 06600	PHYSICAL THERAPY	371,997	13,231	0	116,854	66.00
67.00 06700	OCCUPATIONAL THERAPY	50,364	1,803	0	15,806	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	133,546	14,430	0	41,486	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	217,278	0	0	0	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	91,591	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	239,004	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01 03950	SLEEP DISORDER	167,691	9,583	0	47,813	75.01
75.03 07501	ADULT MENTAL HEALTH	392,397	11,386	0	0	75.03
76.97 07697	CARDIAC REHABILITATION	89,858	2,225	0	26,792	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	1,644,650	23,021	0	247,963	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	17,500,857	389,211	0	2,036,827	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	78,992	13,864	0	24,447	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.01 19301	MARKETING/ PUBLIC RELATIONS	222,617	4,797	0	18,582	193.01
193.02 19302	NEW HORIZON OP	25,885	4,307	0	8,394	193.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	17,828,351	412,179	0	2,088,250	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151314

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

Worksheet B
Part I
Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	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	4,864,691				5.00	
7.00	00700	OPERATION OF PLANT	631,918	2,315,882			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0		8.00	
9.00	00900	HOUSEKEEPING	117,567	123,034	0	553,898	9.00	
10.00	01000	DIETARY	41,101	315,380	0	0	10.00	
11.00	01100	CAFETERIA	94,696	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	34,265	41,660	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	59,467	97,771	0	7,509	14.00	
15.00	01500	PHARMACY	135,132	39,742	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	146,640	93,519	0	7,209	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	434,886	289,451	0	133,368	466,008	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	420,220	300,928	0	156,198	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	395,234	156,523	0	33,642	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	96,449	39,131	0	0	0	58.00
60.00	06000	LABORATORY	499,821	72,453	0	30,639	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	116,433	19,371	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	188,409	97,493	0	13,217	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,507	13,284	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	71,097	106,331	0	9,011	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	81,535	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	34,370	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	89,688	0	0	8,110	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	84,465	70,619	0	24,631	0	75.01
75.03	07501	ADULT MENTAL HEALTH	151,522	83,903	0	7,509	0	75.03
76.97	07697	CARDIAC REHABILITATION	44,609	16,397	0	11,114	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	718,850	169,641	0	95,220	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,713,881	2,146,631	0	537,377	466,008	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	3,605	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44,019	102,162	0	10,213	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	92,311	35,351	0	0	0	193.01
193.02	19302	NEW HORIZON OP	14,480	31,738	0	2,703	0	193.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,864,691	2,315,882	0	553,898	466,008	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151314

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

Worksheet B
Part I
Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	347,046					11.00
13.00	01300	5,166	172,401				13.00
14.00	01400	10,726	0	333,943			14.00
15.00	01500	25,287	0	0	560,268		15.00
16.00	01600	31,168	0	0	0	669,308	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	58,539	24,629	0	0	54,103	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	35,116	21,110	0	0	97,298	50.00
54.00	05400	44,451	22,870	0	0	99,480	54.00
58.00	05800	3,000	0	0	0	0	58.00
60.00	06000	0	17,592	0	0	0	60.00
61.00	06100						61.00
65.00	06500	17,403	0	0	0	0	65.00
66.00	06600	21,628	19,351	0	0	0	66.00
67.00	06700	2,925	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	9,873	1,759	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	316,112	0	0	71.00
72.00	07200	0	0	17,831	0	0	72.00
73.00	07300	0	19,351	0	560,268	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	03950	12,007	0	0	0	0	75.01
75.03	07501	0	0	0	0	0	75.03
76.97	07697	6,126	1,759	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	51,576	22,870	0	0	278,370	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		334,991	151,291	333,943	560,268	529,251	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	6,337	21,110	0	0	140,057	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	3,787	0	0	0	0	193.01
193.02	19302	1,931	0	0	0	0	193.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		347,046	172,401	333,943	560,268	669,308	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151314

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

Worksheet B
Part I
Date/Time Prepared:
11/26/2013 9:45 am

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	2,619,890	0	2,619,890
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,150,692	0	2,150,692
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,805,438	0	1,805,438
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	395,602	0	395,602
60.00	06000	LABORATORY	1,952,451	0	1,952,451
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0
65.00	06500	RESPIRATORY THERAPY	463,482	0	463,482
66.00	06600	PHYSICAL THERAPY	842,180	0	842,180
67.00	06700	OCCUPATIONAL THERAPY	109,689	0	109,689
68.00	06800	SPEECH PATHOLOGY	0	0	0
69.00	06900	ELECTROCARDIOLOGY	387,533	0	387,533
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	614,925	0	614,925
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	143,792	0	143,792
73.00	07300	DRUGS CHARGED TO PATIENTS	916,421	0	916,421
74.00	07400	RENAL DIALYSIS	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0
75.01	03950	SLEEP DISORDER	416,809	0	416,809
75.03	07501	ADULT MENTAL HEALTH	646,717	0	646,717
76.97	07697	CARDIAC REHABILITATION	198,880	0	198,880
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0
90.00	09000	CLINIC	0	0	0
91.00	09100	EMERGENCY	3,252,161	0	3,252,161
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,916,662	0	16,916,662
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	3,605	0	3,605
191.00	19100	RESEARCH	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	441,201	0	441,201
193.00	19300	NONPAID WORKERS	0	0	0
193.01	19301	MARKETING/ PUBLIC RELATIONS	377,445	0	377,445
193.02	19302	NEW HORIZON OP	89,438	0	89,438
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118-201)	17,828,351	0	17,828,351

COST ALLOCATION STATISTICS

Provider CCN: 151314

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

Worksheet Non-CMS W
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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	3	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	5	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	9	HOURS OF SERVICE	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	HOURS	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	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	17	TIME SPENT	16.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151314

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

Worksheet B
Part II
Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
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	503	1,064	0	1,567
5.00	00500	ADMINISTRATIVE & GENERAL	250,615	45,715	0	296,330
7.00	00700	OPERATION OF PLANT	391,723	51,121	0	442,844
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0
9.00	00900	HOUSEKEEPING	0	16,697	0	16,697
10.00	01000	DIETARY	1,122	42,799	0	43,921
11.00	01100	CAFETERIA	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	3,324	5,654	0	8,978
14.00	01400	CENTRAL SERVICES & SUPPLY	1,678	13,268	0	14,946
15.00	01500	PHARMACY	25,036	5,393	0	30,429
16.00	01600	MEDICAL RECORDS & LIBRARY	4,617	12,691	0	17,308
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,389	39,280	0	56,669
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	67,469	40,838	0	108,307
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,310	21,241	0	22,551
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	200,323	5,310	0	205,633
60.00	06000	LABORATORY	1,956	9,832	0	11,788
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY			0	0
65.00	06500	RESPIRATORY THERAPY	2,608	2,629	0	5,237
66.00	06600	PHYSICAL THERAPY	1,718	13,231	0	14,949
67.00	06700	OCCUPATIONAL THERAPY	0	1,803	0	1,803
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	1,966	14,430	0	16,396
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0
75.01	03950	SLEEP DISORDER	7,939	9,583	0	17,522
75.03	07501	ADULT MENTAL HEALTH	0	11,386	0	11,386
76.97	07697	CARDIAC REHABILITATION	0	2,225	0	2,225
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0
90.00	09000	CLINIC	0	0	0	0
91.00	09100	EMERGENCY	4,797	23,021	0	27,818
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	0
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	986,093	389,211	0	1,375,304
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,007	13,864	0	14,871
193.00	19300	NONPAID WORKERS	0	0	0	0
193.01	19301	MARKETING/ PUBLIC RELATIONS	1,668	4,797	0	6,465
193.02	19302	NEW HORIZON OP	0	4,307	0	4,307
200.00		Cross Foot Adjustments			0	0
201.00		Negative Cost Centers		0	0	0
202.00		TOTAL (sum lines 118-201)	988,768	412,179	0	1,400,947

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151314

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

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Part II
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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	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	296,726				5.00
7.00	00700	OPERATION OF PLANT	38,544	481,427			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0		8.00
9.00	00900	HOUSEKEEPING	7,171	25,576	0	49,444	9.00
10.00	01000	DIETARY	2,507	65,559	0	0	10.00
11.00	01100	CAFETERIA	5,776	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,090	8,660	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,627	20,325	0	670	14.00
15.00	01500	PHARMACY	8,242	8,262	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,944	19,441	0	644	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,526	60,171	0	11,905	111,987
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	25,632	62,557	0	13,943	0
54.00	05400	RADIOLOGY - DIAGNOSTIC	24,108	32,538	0	3,003	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,883	8,135	0	0	0
60.00	06000	LABORATORY	30,487	15,062	0	2,735	0
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY					
65.00	06500	RESPIRATORY THERAPY	7,102	4,027	0	0	0
66.00	06600	PHYSICAL THERAPY	11,492	20,267	0	1,180	0
67.00	06700	OCCUPATIONAL THERAPY	1,556	2,762	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	4,337	22,104	0	804	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,973	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	2,096	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	5,471	0	0	724	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	03950	SLEEP DISORDER	5,152	14,680	0	2,199	0
75.03	07501	ADULT MENTAL HEALTH	9,242	17,442	0	670	0
76.97	07697	CARDIAC REHABILITATION	2,721	3,409	0	992	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	43,848	35,265	0	8,500	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	287,527	446,242	0	47,969	111,987
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	322	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,685	21,238	0	912	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	MARKETING/ PUBLIC RELATIONS	5,631	7,349	0	0	0
193.02	19302	NEW HORIZON OP	883	6,598	0	241	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	296,726	481,427	0	49,444	111,987

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151314

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

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Part II
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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	5,776					11.00
13.00	01300	86	19,828				13.00
14.00	01400	179	0	39,770			14.00
15.00	01500	421	0	0	47,404		15.00
16.00	01600	519	0	0	0	46,921	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	974	2,833	0	0	3,793	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	584	2,428	0	0	6,821	50.00
54.00	05400	740	2,630	0	0	6,974	54.00
58.00	05800	50	0	0	0	0	58.00
60.00	06000	0	2,023	0	0	0	60.00
61.00	06100						61.00
65.00	06500	290	0	0	0	0	65.00
66.00	06600	360	2,226	0	0	0	66.00
67.00	06700	49	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	164	202	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	37,646	0	0	71.00
72.00	07200	0	0	2,124	0	0	72.00
73.00	07300	0	2,226	0	47,404	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	03950	200	0	0	0	0	75.01
75.03	07501	0	0	0	0	0	75.03
76.97	07697	102	202	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	858	2,630	0	0	19,514	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		5,576	17,400	39,770	47,404	37,102	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	105	2,428	0	0	9,819	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	63	0	0	0	0	193.01
193.02	19302	32	0	0	0	0	193.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		5,776	19,828	39,770	47,404	46,921	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151314

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

Worksheet B
Part II
Date/Time Prepared:
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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				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	275,057	0	275,057	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	220,420	0	220,420	50.00
54.00	05400	92,700	0	92,700	54.00
58.00	05800	219,713	0	219,713	58.00
60.00	06000	62,095	0	62,095	60.00
61.00	06100				61.00
65.00	06500	16,710	0	16,710	65.00
66.00	06600	50,562	0	50,562	66.00
67.00	06700	6,182	0	6,182	67.00
68.00	06800	0	0	0	68.00
69.00	06900	44,038	0	44,038	69.00
70.00	07000	0	0	0	70.00
71.00	07100	42,619	0	42,619	71.00
72.00	07200	4,220	0	4,220	72.00
73.00	07300	55,825	0	55,825	73.00
74.00	07400	0	0	0	74.00
75.00	07500	0	0	0	75.00
75.01	03950	39,789	0	39,789	75.01
75.03	07501	38,740	0	38,740	75.03
76.97	07697	9,671	0	9,671	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	0	0	0	90.00
91.00	09100	138,619	0	138,619	91.00
92.00	09200	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
118.00		1,316,960	0	1,316,960	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	322	0	322	190.00
191.00	19100	0	0	0	191.00
192.00	19200	52,076	0	52,076	192.00
193.00	19300	0	0	0	193.00
193.01	19301	19,522	0	19,522	193.01
193.02	19302	12,067	0	12,067	193.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		1,400,947	0	1,400,947	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151314

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

Worksheet B-1

Date/Time Prepared:
11/26/2013 9:45 am

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	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	109,287					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	282	0	6,368,215			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	12,121	0	1,607,986	-4,864,691	12,963,660	5.00
7.00 00700	OPERATION OF PLANT	13,554	0	157,466	0	1,683,964	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	4,427	0	0	0	313,297	9.00
10.00 01000	DIETARY	11,348	0	0	0	109,527	10.00
11.00 01100	CAFETERIA	0	0	0	0	252,350	11.00
13.00 01300	NURSING ADMINISTRATION	1,499	0	57,789	0	91,310	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	3,518	0	92,020	0	158,470	14.00
15.00 01500	PHARMACY	1,430	0	203,166	0	360,107	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,365	0	266,050	0	390,772	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	10,415	0	808,958	0	1,158,906	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	10,828	0	602,734	0	1,119,822	50.00
54.00 05400	RADIOLOGY - DIAGNOSTIC	5,632	0	635,450	0	1,053,238	54.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,408	0	46,829	0	257,022	58.00
60.00 06000	LABORATORY	2,607	0	0	0	1,331,946	60.00
61.00 06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00 06500	RESPIRATORY THERAPY	697	0	218,200	0	310,275	65.00
66.00 06600	PHYSICAL THERAPY	3,508	0	356,350	0	502,082	66.00
67.00 06700	OCCUPATIONAL THERAPY	478	0	48,202	0	67,973	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	3,826	0	126,513	0	189,462	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	217,278	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	91,591	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	239,004	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01 03950	SLEEP DISORDER	2,541	0	145,807	0	225,087	75.01
75.03 07501	ADULT MENTAL HEALTH	3,019	0	0	0	403,783	75.03
76.97 07697	CARDIAC REHABILITATION	590	0	81,704	0	118,875	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	6,104	0	756,173	0	1,915,634	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	103,197	0	6,211,397	-4,864,691	12,561,775	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	3,676	0	74,553	0	117,303	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301	MARKETING/ PUBLIC RELATIONS	1,272	0	56,666	0	245,996	193.01
193.02 19302	NEW HORIZON OP	1,142	0	25,599	0	38,586	193.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	412,179	0	2,088,250		4,864,691	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	3.771528	0.000000	0.327918		0.375256	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			1,567		296,726	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000246		0.022889	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151314

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

Worksheet B-1

Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (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	83,330				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0			8.00
9.00	00900	HOUSEKEEPING	4,427	0	1,844		9.00
10.00	01000	DIETARY	11,348	0	0	1,123	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,499	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,518	0	25	0	14.00
15.00	01500	PHARMACY	1,430	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,365	0	24	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,415	0	444	1,123	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,828	0	520	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	5,632	0	112	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,408	0	0	0	58.00
60.00	06000	LABORATORY	2,607	0	102	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY					61.00
65.00	06500	RESPIRATORY THERAPY	697	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,508	0	44	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	478	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,826	0	30	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	27	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	2,541	0	82	0	75.01
75.03	07501	ADULT MENTAL HEALTH	3,019	0	25	0	75.03
76.97	07697	CARDIAC REHABILITATION	590	0	37	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,104	0	317	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	77,240	0	1,789	1,123	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	12	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,676	0	34	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	1,272	0	0	0	193.01
193.02	19302	NEW HORIZON OP	1,142	0	9	0	193.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per wkst. B, Part I)	2,315,882	0	553,898	466,008	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	27.791696	0.000000	300.378525	414.967053	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	481,427	0	49,444	111,987	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	5.777355	0.000000	26.813449	99.721282	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151314

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

Worksheet B-1

Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
GENERAL SERVICE COST CENTERS		13.00	14.00	15.00	16.00	
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	98				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	6,480			14.00
15.00	01500 PHARMACY	0	0	100		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	1,534	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	14	0	0	124	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	12	0	0	223	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	13	0	0	228	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000 LABORATORY	10	0	0	0	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY					61.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	11	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	1	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,134	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	346	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	11	0	100	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	03950 SLEEP DISORDER	0	0	0	0	75.01
75.03	07501 ADULT MENTAL HEALTH	0	0	0	0	75.03
76.97	07697 CARDIAC REHABILITATION	1	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	90.00
91.00	09100 EMERGENCY	13	0	0	638	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	86	6,480	100	1,213	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
191.00	19100 RESEARCH	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	12	0	0	321	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	193.00
193.01	19301 MARKETING/ PUBLIC RELATIONS	0	0	0	0	193.01
193.02	19302 NEW HORIZON OP	0	0	0	0	193.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)	172,401	333,943	560,268	669,308	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1,759.193878	51.534414	5,602.680000	436.315515	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	19,828	39,770	47,404	46,921	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	202.326531	6.137346	474.040000	30.587353	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,619,890		2,619,890	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,150,692		2,150,692	0	0	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	1,805,438		1,805,438	0	0	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	395,602		395,602	0	0	58.00
60.00	06000 LABORATORY	1,952,451		1,952,451	0	0	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0		0	0	0	61.00
65.00	06500 RESPIRATORY THERAPY	463,482	0	463,482	0	0	65.00
66.00	06600 PHYSICAL THERAPY	842,180	0	842,180	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	109,689	0	109,689	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	387,533		387,533	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	614,925		614,925	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	143,792		143,792	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	916,421		916,421	0	0	73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	03950 SLEEP DISORDER	416,809		416,809	0	0	75.01
75.03	07501 ADULT MENTAL HEALTH	646,717		646,717	0	0	75.03
76.97	07697 CARDIAC REHABILITATION	198,880		198,880	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	3,252,161		3,252,161	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	612,008		612,008	0	0	92.00
200.00	Subtotal (see instructions)	17,528,670	0	17,528,670	0	0	200.00
201.00	Less observation Beds	612,008		612,008	0	0	201.00
202.00	Total (see instructions)	16,916,662	0	16,916,662	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C
Part I
Date/Time Prepared:
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		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	3,387,020		3,387,020			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	468,101	6,189,800	6,657,901	0.323029	0.000000	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	329,005	9,968,783	10,297,788	0.175323	0.000000	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	21,330	2,150,994	2,172,324	0.182110	0.000000	58.00
60.00	06000 LABORATORY	614,741	7,345,335	7,960,076	0.245280	0.000000	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	0.000000	61.00
65.00	06500 RESPIRATORY THERAPY	209,056	651,578	860,634	0.538536	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	269,222	2,202,937	2,472,159	0.340666	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	62,432	271,963	334,395	0.328022	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	93,300	1,390,629	1,483,929	0.261153	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	543,830	1,110,678	1,654,508	0.371666	0.000000	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	34,327	172,025	206,352	0.696829	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	638,231	1,524,369	2,162,600	0.423759	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	03950 SLEEP DISORDER	0	877,235	877,235	0.475140	0.000000	75.01
75.03	07501 ADULT MENTAL HEALTH	0	870,579	870,579	0.742858	0.000000	75.03
76.97	07697 CARDIAC REHABILITATION	384	167,372	167,756	1.185531	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000 CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100 EMERGENCY	118,545	6,077,037	6,195,582	0.524916	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	19,133	238,526	257,659	2.375263	0.000000	92.00
200.00	Subtotal (see instructions)	6,808,657	41,209,840	48,018,497			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	6,808,657	41,209,840	48,018,497			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.000000			54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000			61.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000			75.00
75.01	03950 SLEEP DISORDER	0.000000			75.01
75.03	07501 ADULT MENTAL HEALTH	0.000000			75.03
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX Hospital Cost				
			Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		2,619,890	2,619,890	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		2,150,692	2,150,692	0	0	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC		1,805,438	1,805,438	0	0	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		395,602	395,602	0	0	58.00
60.00	06000 LABORATORY		1,952,451	1,952,451	0	0	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0	0	0	0	61.00
65.00	06500 RESPIRATORY THERAPY	0	463,482	463,482	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	842,180	842,180	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	109,689	109,689	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	387,533	387,533	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	614,925	614,925	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	143,792	143,792	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	916,421	916,421	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950 SLEEP DISORDER	0	416,809	416,809	0	0	75.01
75.03	07501 ADULT MENTAL HEALTH	0	646,717	646,717	0	0	75.03
76.97	07697 CARDIAC REHABILITATION	0	198,880	198,880	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC		0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	89.00
90.00	09000 CLINIC		0	0	0	0	90.00
91.00	09100 EMERGENCY		3,252,161	3,252,161	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		612,008	612,008	0	0	92.00
200.00	Subtotal (see instructions)	0	17,528,670	17,528,670	0	0	200.00
201.00	Less Observation Beds		612,008	612,008	0	0	201.00
202.00	Total (see instructions)	0	16,916,662	16,916,662	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:45 am

		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	3,387,020	3,387,020			30.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	468,101	6,189,800	6,657,901	0.323029	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	329,005	9,968,783	10,297,788	0.175323	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	21,330	2,150,994	2,172,324	0.182110	0.000000	58.00
60.00	06000	LABORATORY	614,741	7,345,335	7,960,076	0.245280	0.000000	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	0.000000	61.00
65.00	06500	RESPIRATORY THERAPY	209,056	651,578	860,634	0.538536	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	269,222	2,202,937	2,472,159	0.340666	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,432	271,963	334,395	0.328022	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	93,300	1,390,629	1,483,929	0.261153	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	543,830	1,110,678	1,654,508	0.371666	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	34,327	172,025	206,352	0.696829	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	638,231	1,524,369	2,162,600	0.423759	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	03950	SLEEP DISORDER	0	877,235	877,235	0.475140	0.000000	75.01
75.03	07501	ADULT MENTAL HEALTH	0	870,579	870,579	0.742858	0.000000	75.03
76.97	07697	CARDIAC REHABILITATION	384	167,372	167,756	1.185531	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	118,545	6,077,037	6,195,582	0.524916	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	19,133	238,526	257,659	2.375263	0.000000	92.00
200.00		Subtotal (see instructions)	6,808,657	41,209,840	48,018,497			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,808,657	41,209,840	48,018,497			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.000000			54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000			61.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000			75.00
75.01	03950 SLEEP DISORDER	0.000000			75.01
75.03	07501 ADULT MENTAL HEALTH	0.000000			75.03
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151314	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part II Date/Time Prepared: 11/26/2013 9:45 am
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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	220,420	6,657,901	0.033107	163,874	5,425	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	92,700	10,297,788	0.009002	85,759	772	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	219,713	2,172,324	0.101142	8,461	856	58.00
60.00	06000	LABORATORY	62,095	7,960,076	0.007801	245,284	1,913	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	16,710	860,634	0.019416	77,342	1,502	65.00
66.00	06600	PHYSICAL THERAPY	50,562	2,472,159	0.020453	57,583	1,178	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,182	334,395	0.018487	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	44,038	1,483,929	0.029677	69,131	2,052	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,619	1,654,508	0.025759	209,668	5,401	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	4,220	206,352	0.020450	25,848	529	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,825	2,162,600	0.025814	226,791	5,854	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	03950	SLEEP DISORDER	39,789	877,235	0.045357	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	38,740	870,579	0.044499	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	9,671	167,756	0.057649	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	138,619	6,195,582	0.022374	373	8	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	257,659	0.000000	0	0	92.00
200.00		Total (lines 50-199)	1,041,903	44,631,477		1,170,114	25,490	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description		Title XVIII				Hospital	Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D Part IV Date/Time Prepared: 11/26/2013 9:45 am

Cost Center Description			Title XVIII			Hospital		Cost
			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	6,657,901	0.000000	0.000000	163,874	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	10,297,788	0.000000	0.000000	85,759	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,172,324	0.000000	0.000000	8,461	58.00
60.00	06000	LABORATORY	0	7,960,076	0.000000	0.000000	245,284	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0					61.00
65.00	06500	RESPIRATORY THERAPY	0	860,634	0.000000	0.000000	77,342	65.00
66.00	06600	PHYSICAL THERAPY	0	2,472,159	0.000000	0.000000	57,583	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	334,395	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,483,929	0.000000	0.000000	69,131	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,654,508	0.000000	0.000000	209,668	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	206,352	0.000000	0.000000	25,848	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,162,600	0.000000	0.000000	226,791	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	03950	SLEEP DISORDER	0	877,235	0.000000	0.000000	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	870,579	0.000000	0.000000	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	167,756	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	6,195,582	0.000000	0.000000	373	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	257,659	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	44,631,477			1,170,114	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 9:45 am

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
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Cost	
		23.00	24.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	03950	SLEEP DISORDER	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151314

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

Worksheet D
Part V
Date/Time Prepared:
11/26/2013 9:45 am

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges		Costs	
				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	0.323029	0	1,920,602	0	0 50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.175323	0	2,846,076	0	0 54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.182110	0	664,410	0	0 58.00
60.00	06000	LABORATORY	0.245280	0	2,489,442	0	0 60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	0	0 61.00
65.00	06500	RESPIRATORY THERAPY	0.538536	0	93,415	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.340666	0	703,141	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.328022	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.261153	0	1,117,331	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.371666	0	406,767	0	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.696829	0	55,639	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.423759	0	1,051,785	2,915	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0 75.00
75.01	03950	SLEEP DISORDER	0.475140	0	0	0	0 75.01
75.03	07501	ADULT MENTAL HEALTH	0.742858	0	635,315	0	0 75.03
76.97	07697	CARDIAC REHABILITATION	1.185531	0	54,317	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0 89.00
90.00	09000	CLINIC	0.000000	0	0	0	0 90.00
91.00	09100	EMERGENCY	0.524916	0	1,471,335	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.375263	0	172,137	0	0 92.00
200.00		Subtotal (see instructions)		0	13,681,712	2,915	0 200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0	0	0 201.00
202.00		Net Charges (line 200 +/- line 201)		0	13,681,712	2,915	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151314

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

Worksheet D
Part V
Date/Time Prepared:
11/26/2013 9:45 am

		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	620,410	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	498,983	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	120,996	0	58.00
60.00	06000	LABORATORY	610,610	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	50,307	0	65.00
66.00	06600	PHYSICAL THERAPY	239,536	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	291,794	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	151,181	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	38,771	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	445,703	1,235	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	03950	SLEEP DISORDER	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	471,949	0	75.03
76.97	07697	CARDIAC REHABILITATION	64,394	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	772,327	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	408,871	0	92.00
200.00		Subtotal (see instructions)	4,785,832	1,235	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	4,785,832	1,235	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151314 Component CCN: 15z314	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/26/2013 9:45 am
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		Title XVIII				Swing Beds - SNF	Cost	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.323029	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.175323	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.182110	0	0	0	0	58.00
60.00	06000	LABORATORY	0.245280	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	0.538536	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.340666	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.328022	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.261153	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.371666	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.696829	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.423759	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0.475140	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0.742858	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	1.185531	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.524916	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.375263	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151314 Component CCN: 15z314	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/26/2013 9:45 am
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
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0		54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00 06000 LABORATORY	0	0		60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		61.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
75.01 03950 SLEEP DISORDER	0	0		75.01
75.03 07501 ADULT MENTAL HEALTH	0	0		75.03
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151314		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part I Date/Time Prepared: 11/26/2013 9:45 am		
Title XIX			Hospital		Cost			
Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	275,057	57,402	217,655	1,293	168.33	30.00	
200.00	Total (lines 30-199)	275,057		217,655	1,293		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	33	5,555					30.00
200.00	Total (lines 30-199)	33	5,555					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151314

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

Worksheet D
Part II
Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description			Title XIX			Hospital	Cost	
			Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	220,420	6,657,901	0.033107	5,734	190	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	92,700	10,297,788	0.009002	57,244	515	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	219,713	2,172,324	0.101142	0	0	58.00
60.00	06000	LABORATORY	62,095	7,960,076	0.007801	60,318	471	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	16,710	860,634	0.019416	42,493	825	65.00
66.00	06600	PHYSICAL THERAPY	50,562	2,472,159	0.020453	1,735	35	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,182	334,395	0.018487	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	44,038	1,483,929	0.029677	6,219	185	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,619	1,654,508	0.025759	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	4,220	206,352	0.020450	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,825	2,162,600	0.025814	39,552	1,021	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	03950	SLEEP DISORDER	39,789	877,235	0.045357	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	38,740	870,579	0.044499	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	9,671	167,756	0.057649	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	138,619	6,195,582	0.022374	41,550	930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	257,659	0.000000	0	0	92.00
200.00		Total (lines 50-199)	1,041,903	44,631,477		254,845	4,172	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151314		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part III Date/Time Prepared: 11/26/2013 9:45 am	
Cost Center Description			Title XIX			Hospital		Cost
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,293	0.00	33	0	0	30.00
200.00		Total (lines 30-199)	1,293		33	0	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				
200.00		Total (lines 30-199)	0	0				

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D Part IV Date/Time Prepared: 11/26/2013 9:45 am

Cost Center Description	Title XIX				Hospital	Cost	Total Cost (sum of col 1 through col. 4)	
	Non-Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description		Title XIX			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		Cost
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,657,901	0.000000	0.000000	5,734	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	10,297,788	0.000000	0.000000	57,244	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,172,324	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	7,960,076	0.000000	0.000000	60,318	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0					61.00
65.00	06500	RESPIRATORY THERAPY	0	860,634	0.000000	0.000000	42,493	65.00
66.00	06600	PHYSICAL THERAPY	0	2,472,159	0.000000	0.000000	1,735	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	334,395	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,483,929	0.000000	0.000000	6,219	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,654,508	0.000000	0.000000	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	206,352	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,162,600	0.000000	0.000000	39,552	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	03950	SLEEP DISORDER	0	877,235	0.000000	0.000000	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	870,579	0.000000	0.000000	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	167,756	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	6,195,582	0.000000	0.000000	41,550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	257,659	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	44,631,477			254,845	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description		Title XIX			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
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 9:45 am

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
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY				61.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	03950	SLEEP DISORDER	0	0		75.01
75.03	07501	ADULT MENTAL HEALTH	0	0		75.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151314	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/26/2013 9:45 am
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)			1,758 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,293 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)			909 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			170 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)			171 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			62 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)			62 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			514 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)			170 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)			171 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)			2,619,890 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)			7,834 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)			7,834 25.00
26.00	Total swing-bed cost (see instructions)			559,144 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,060,746 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)			2,060,746 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)			1,593.77 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			819,198 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)			819,198 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151314	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/26/2013 9:45 am
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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)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					401,237
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,220,435
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
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					270,941
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					272,535
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					543,476
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					384
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,593.77
89.00 Observation bed cost (line 87 x line 88) (see instructions)					612,008

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151314	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/26/2013 9:45 am
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Cost Center Description	Cost	Title XVIII		Hospital	Cost
		Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
	1.00	2.00	3.00	4.00	5.00
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: 151314

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

Worksheet D-1

Date/Time Prepared:
11/26/2013 9:45 am

Title XIX		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,758	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,293	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)	909	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	170	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)	171	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	62	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)	62	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	33	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,619,890	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	546,746	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,073,144	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)	2,073,144	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)	1,603.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	52,911	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)	52,911	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151314	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1	
		Title XIX		Hospital	Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)				90,353 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				143,264 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0 54.00
55.00	Target amount per discharge				0.00 55.00
56.00	Target amount (line 54 x line 55)				0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0 57.00
58.00	Bonus payment (see instructions)				0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0 61.00
62.00	Relief payment (see instructions)				0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				384 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,603.36 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				615,690 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151314

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

Worksheet D-1

Date/Time Prepared:
11/26/2013 9:45 am

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151314	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/26/2013 9:45 am
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		441,553		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.323029	163,874	52,936	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.175323	85,759	15,036	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.182110	8,461	1,541	58.00
60.00	06000 LABORATORY	0.245280	245,284	60,163	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
65.00	06500 RESPIRATORY THERAPY	0.538536	77,342	41,651	65.00
66.00	06600 PHYSICAL THERAPY	0.340666	57,583	19,617	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.328022	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.261153	69,131	18,054	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.371666	209,668	77,926	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.696829	25,848	18,012	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.423759	226,791	96,105	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03950 SLEEP DISORDER	0.475140	0	0	75.01
75.03	07501 ADULT MENTAL HEALTH	0.742858	0	0	75.03
76.97	07697 CARDIAC REHABILITATION	1.185531	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.524916	373	196	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.375263	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,170,114	401,237	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)		1,170,114		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151314
Component CCN: 152314

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

Worksheet D-3
Date/Time Prepared:
11/26/2013 9:45 am

Title XVIII		Swing Beds - SNF			Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.323029	4,595	1,484	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.175323	14,810	2,597	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.182110	3,157	575	58.00
60.00	06000 LABORATORY	0.245280	69,666	17,088	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
65.00	06500 RESPIRATORY THERAPY	0.538536	18,412	9,916	65.00
66.00	06600 PHYSICAL THERAPY	0.340666	175,734	59,867	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.328022	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.261153	17,950	4,688	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.371666	57,470	21,360	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.696829	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.423759	90,242	38,241	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03950 SLEEP DISORDER	0.475140	0	0	75.01
75.03	07501 ADULT MENTAL HEALTH	0.742858	0	0	75.03
76.97	07697 CARDIAC REHABILITATION	1.185531	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.524916	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.375263	624	1,482	92.00
200.00	Total (sum of lines 50-94 and 96-98)		452,660	157,298	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)		452,660		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151314	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/26/2013 9:45 am
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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		142,884	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.323029	5,734	1,852 50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.175323	57,244	10,036 54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.182110	0	0 58.00
60.00	06000	LABORATORY	0.245280	60,318	14,795 60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0 61.00
65.00	06500	RESPIRATORY THERAPY	0.538536	42,493	22,884 65.00
66.00	06600	PHYSICAL THERAPY	0.340666	1,735	591 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.328022	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.261153	6,219	1,624 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.371666	0	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.696829	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.423759	39,552	16,761 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0 75.00
75.01	03950	SLEEP DISORDER	0.475140	0	0 75.01
75.03	07501	ADULT MENTAL HEALTH	0.742858	0	0 75.03
76.97	07697	CARDIAC REHABILITATION	1.185531	0	0 76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0 89.00
90.00	09000	CLINIC	0.000000	0	0 90.00
91.00	09100	EMERGENCY	0.524916	41,550	21,810 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.375263	0	0 92.00
200.00		Total (sum of lines 50-94 and 96-98)		254,845	90,353 200.00
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)		254,845	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151314	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/26/2013 9:45 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,787,067 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)			4,787,067 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)			4,834,938 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)			21,545 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,241,732 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)			2,571,661 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)			2,571,661 30.00
31.00	Primary payer payments			543 31.00
32.00	Subtotal (line 30 minus line 31)			2,571,118 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)			476,665 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			476,665 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			476,665 36.00
37.00	Subtotal (see instructions)			3,047,783 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00				0 39.00
39.01				9 39.01
39.98				0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			3,047,792 40.00
40.01	Sequestration adjustment (see instructions)			15,239 40.01
41.00	Interim payments			2,830,491 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			202,062 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: 151314

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

Worksheet E-1
Part I
Date/Time Prepared:
11/26/2013 9:45 am

		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		1,096,131		2,830,491	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
3.49			0		0	3.49
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	01/22/2013	141,300		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)		-141,300		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)		954,831		2,830,491	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		130,964		217,301	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,085,795		3,047,792	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: 151314
Component CCN: 15Z314

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

Worksheet E-1
Part I
Date/Time Prepared:
11/26/2013 9:45 am

		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		543,647		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
3.49			0		0		3.49
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	01/22/2013	79,900		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)		-79,900		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)		463,747		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		241,120		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		704,867		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: 151314	Period: From 07/01/2012	Worksheet E-2
	Component CCN: 152314	To 06/30/2013	Date/Time Prepared: 11/26/2013 9:45 am

		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)	548,911	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)	158,871	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	341	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)	707,782	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	707,782	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)	707,782	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,915	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	704,867	0	15.00
16.00	Allowable bad debts (see instructions)	0	0	16.00
17.00	Adjusted reimbursable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	704,867	0	19.00
19.01	Sequestration adjustment (see instructions)	3,524	0	19.01
20.00	Interim payments	463,747	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	237,596	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: 151314	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part V Date/Time Prepared: 11/26/2013 9:45 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			1,220,435 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			1,220,435 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,232,639 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)			1,232,639 19.00
20.00	Deductibles (exclude professional component)			145,956 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			1,086,683 22.00
23.00	Coinsurance			888 23.00
24.00	Subtotal (line 22 minus line 23)			1,085,795 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			0 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,085,795 28.00
29.00				0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			1,085,795 30.00
30.01	Sequestration adjustment (see instructions)			5,429 30.01
31.00	Interim payments			954,831 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			125,535 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: 151314	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2013 9:45 am	
		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		143,264		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)		143,264	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)		143,264	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		142,884		8.00
9.00	Ancillary service charges		254,845	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)		397,729	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)		397,729	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		254,465	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)		143,264	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		143,264	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)		143,264	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		143,264	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		143,264	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)		143,264	0	40.00
41.00	Interim payments		143,264	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 151314

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

Worksheet G

Date/Time Prepared:
11/26/2013 9:45 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	644,574	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,966,656	0	0	0	4.00
5.00	Other receivable	508,806	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,310,318	0	0	0	6.00
7.00	Inventory	286,528	0	0	0	7.00
8.00	Prepaid expenses	654,890	0	0	0	8.00
9.00	Other current assets	44,073	0	0	0	9.00
10.00	Due from other funds	155,926	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,951,135	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	159,641	0	0	0	15.00
16.00	Accumulated depreciation	-5,853	0	0	0	16.00
17.00	Leasehold improvements	856,968	0	0	0	17.00
18.00	Accumulated depreciation	-467,290	0	0	0	18.00
19.00	Fixed equipment	503,807	0	0	0	19.00
20.00	Accumulated depreciation	-230,269	0	0	0	20.00
21.00	Automobiles and trucks	13,500	0	0	0	21.00
22.00	Accumulated depreciation	-4,781	0	0	0	22.00
23.00	Major movable equipment	338,906	0	0	0	23.00
24.00	Accumulated depreciation	-122,104	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)	1,042,525	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	8,656,673	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,656,673	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	13,650,333	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	503,241	0	0	0	37.00
38.00	Salaries, wages, and fees payable	441,751	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	610,143	0	0	0	43.00
44.00	Other current liabilities	1,654,938	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,210,073	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	913,759	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	913,759	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,123,832	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	9,526,501				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	9,526,501	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,650,333	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151314

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

Worksheet G-1

Date/Time Prepared:
11/26/2013 9:45 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		7,952,169		0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		1,535,415			2.00
3.00	Total (sum of line 1 and line 2)		9,487,584		0	3.00
4.00	DONATION	10,478		0		4.00
5.00	GRANT REVENUE	21,871		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		32,349		0	10.00
11.00	Subtotal (line 3 plus line 10)		9,519,933		0	11.00
12.00	PENSION RELATED NA ADJ	-45,676		0		12.00
13.00	RELEASED OPERATING	39,108		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		-6,568		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,526,501		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	DONATION		0			4.00
5.00	GRANT REVENUE		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	PENSION RELATED NA ADJ		0			12.00
13.00	RELEASED OPERATING		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151314

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/26/2013 9:45 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,650,635		3,650,635	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,650,635		3,650,635	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,650,635		3,650,635	17.00
18.00	Ancillary services	3,229,836	34,927,921	38,157,757	18.00
19.00	Outpatient services	119,584	6,090,560	6,210,144	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	7,000,055	41,018,481	48,018,536	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		18,115,734		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)		18,115,734		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151314

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

Worksheet G-3

Date/Time Prepared:
11/26/2013 1:13 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	48,018,536	1.00
2.00	Less contractual allowances and discounts on patients' accounts	28,981,119	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,037,417	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	18,115,734	4.00
5.00	Net income from service to patients (line 3 minus line 4)	921,683	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	65,782	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	23,567	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	112,151	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANTS	11,369	24.00
24.01	MISC REVENUE	5,201	24.01
24.02	NET ASSETS RELEASED FROM RESTRICTION	39,108	24.02
24.03	NONOPERATING GAINS/LOSSES	391,119	24.03
24.04	PENSION CURTAILMENT	-34,565	24.04
24.05		0	24.05
24.06		0	24.06
25.00	Total other income (sum of lines 6-24)	613,732	25.00
26.00	Total (line 5 plus line 25)	1,535,415	26.00
27.00		0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,535,415	29.00

CMS 339 Questionnaire - Exhibit 1
 Date Prepared: 11/26/2013 9:47:12 AM
 Data File: X:\HFSdata\clients\Hospital\St Vincent\Salem\28800-13.mcrx
 Fiscal Year: 07/01/2012 To 06/30/2013
 Provider Name: ST VINCENT SALEM
 Provider No: 151314

Health Financial Systems
 MCRIF32

Allocation of Physician Compensation: Hours
Department: EMERGENCY DEPARTMENT
Physician: AGGREGATE EMERGENCY PHYSICIANS
Provider: ST VINCENT SALEM
Number: 151314
Specialty: EMERGENCY MEDICINE-EMERGENCY M

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

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Health Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	7349.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	7349.00
2. Physician Services: Medical and Surgical Services to Individual Patients.	0.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	1411.00
4. Total Hours (Lines 1D, 2, and 3)	8760.00
5. Professional Component Percentage (Line 2 / Line 4)	0.00 %
6. Provider Component Percentage - (Line 1D / Line 4)	83.89 %

 Signature: Physician or Physician Department Head

 Date

v7

CMS 339 Questionnaire - Exhibit 1
 Date Prepared: 11/26/2013 9:47:12 AM
 Data File: X:\HFSdata\clients\Hospital\St Vincent\Salem\28800-13.mcrx
 Fiscal Year: 07/01/2012 To 06/30/2013
 Provider Name: ST VINCENT SALEM
 Provider No: 151314

Health Financial Systems
 MCRIF32

Allocation of Physician Compensation: Hours **Provider:** ST VINCENT SALEM
Department: FAM PRACTICE RES PROGRAM **Number:** 151314
Physician: AGGREGATE ADULTS & PEDIATRICS PHYSICIANS **Specialty:** INTERNAL MEDICINE-GENERAL

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

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

Signature: Physician or Physician Department Head Date v7

CMS 339 Questionnaire - Exhibit 1
 Date Prepared: 11/26/2013 9:47:12 AM
 Data File: X:\HFSdata\clients\Hospital\St Vincent\Salem\28800-13.mcrx
 Fiscal Year: 07/01/2012 To 06/30/2013
 Provider Name: ST VINCENT SALEM
 Provider No: 151314

Health Financial Systems
 MCRIF32

Allocation of Physician Compensation: Hours **Provider:** ST VINCENT SALEM
Department: RADIOLOGY **Number:** 151314
Physician: NORTHWEST RADIOLOGY PHYSICIANS **Specialty:** RADIOLOGICAL IMAGING-GENERAL

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

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Health Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	0.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	0.00
2. Physician Services: Medical and Surgical Services to Individual Patients.	266.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	1814.00
4. Total Hours (Lines 1D, 2, and 3)	2080.00
5. Professional Component Percentage (Line 2 / Line 4)	12.79 %
6. Provider Component Percentage - (Line 1D / Line 4)	0.00 %

 Signature: Physician or Physician Department Head

 Date

v7

CMS 339 Questionnaire - Exhibit 1
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 Data File: X:\HFSdata\clients\Hospital\St Vincent\Salem\28800-13.mcrx
 Fiscal Year: 07/01/2012 To 06/30/2013
 Provider Name: ST VINCENT SALEM
 Provider No: 151314

Health Financial Systems
 MCRIF32

Allocation of Physician Compensation: Hours **Provider:** ST VINCENT SALEM
Department: PULMONARY SERVICES **Number:** 151314
Physician: SLEEP CENTER SERVICES PHYSICIANS **Specialty:** INTERNAL MEDICINE-PULMONARY DIS

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

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

 Signature: Physician or Physician Department Head

 Date

v7

Date Prepared: 11/26/2013 9:47:12 AM

Data File: X:\HFSdata\clients\Hospital\St Vincent\Salem\28800-13.mcrx

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

Provider Name: ST VINCENT SALEM

Health Financial Systems

Provider No: 151314

MCRIF32

Allocation of Physician Compensation: Hours

Provider:

ST VINCENT SALEM

Department: SURGERY

Number:

151314

Physician: AGGREGATE SURGERY PHYSICIANS

Specialty:

SURGERY-GENERAL

Basis of Allocation: Time Study

Describe:

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

Signature: Physician or Physician Department Head

Date

v7