

**ST. VINCENT JENNINGS HOSPITAL**

**PROVIDER NO. 15-1303, 15-Z303, AND AIM NO. 200360180**

**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: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet S Parts I-III Date/Time Prepared: 11/26/2013 11:51 am
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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: 11:51 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN
		10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT JENNINGS HOSPITAL ( 151303 ) 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: 11:51 am  
MM1izjPTgTBnojFY2P30fGwEejkva0  
86kSp0mELQRQErCUL8g5v3AX.ks88M  
aam80suwsa0xi60p  
PI: Date: 11/26/2013 Time: 11:51 am  
RXbton7:o6xlC2Gh1ELgSbu1hvoM.0  
z9B8Q0Q07ueT9TtxByMYHv9tjSYckb  
5Vc.0uUTuu0EvPgG

(Signed)

\_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-117,560	-573,132	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	-24,891	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
200.00 Total	0	-142,451	-573,132	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: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/25/2013 5:37 pm
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		1.00	2.00	3.00	4.00				
<b>Hospital and Hospital Health Care Complex Address:</b>									
1.00	Street: 301 HENRY STREET	PO Box:		Zip Code: 47265		County: JENNINGS		1.00	
2.00	City: NORTH VERNON	State: IN						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
<b>Hospital and Hospital-Based Component Identification:</b>									
3.00	Hospital	ST. VINCENT JENNINGS HOSPITAL	151303	99915	1	07/01/1996	N	O	P
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF	ST. VINCENT JENNINGS SWING BED	152303	99915		07/05/1991	N	O	N
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2012	06/30/2013		
21.00	Type of Control (see instructions)					2			
<b>Inpatient PPS Information</b>									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		
						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			
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			
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			

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

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	

<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00

64.00	<b>Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</b> Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
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		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00

66.00	<b>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</b> Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151303

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

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Part I  
Date/Time Prepared:  
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
						1.00 2.00 3.00
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			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
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00
						1.00
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
						V XIX
						1.00 2.00
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	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
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N		106.00

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		V 1.00	XIX 2.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N
				1.00	2.00
				3.00	
<b>Miscellaneous Cost Reporting Information</b>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0
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:	1	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
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		15HO46	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/25/2013 5:37 pm
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1.00		2.00		3.00		
<b>If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.</b>						
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08101		141.00
142.00	Street: 10330 N. MERIDAN ST	PO Box:				142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290			143.00

144.00	Are provider based physicians' costs included in worksheet A?	1.00	Y	144.00
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
<b>Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)</b>						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

<b>Multicampus</b>							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0.00	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/25/2013 5:37 pm	
		Y/N	Date		
		1.00	2.00		
<b>General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.</b>					
<b>COMPLETED BY ALL HOSPITALS</b>					
<b>Provider Organization and Operation</b>					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
<b>Financial Data and Reports</b>					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
<b>Approved Educational Activities</b>					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
<b>Bad Debts</b>					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
<b>Bed Complement</b>					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y		15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
<b>PS&amp;R Data</b>					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/02/2013	Y	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/25/2013 5:37 pm
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
	0	1.00	2.00	3.00	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
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			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			Y	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.			Y	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	NANCY		GAYLE	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 583-3236		NKGAYLE@STVINCENT.ORG	43.00

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

Provider CCN: 151303

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

Worksheet S-2  
Part IX  
Date/Time Prepared:  
11/25/2013 5:37 pm

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

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	28,848.00	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	28,848.00	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	28,848.00	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						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151303

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/25/2013 5:37 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	667	102	1,202			1.00
2.00 HMO and other (see instructions)	88	66				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	318	0	318			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	11			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	985	102	1,531			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)	985	102	1,531	0.00	112.76	14.00
15.00 CAH visits	9,843	2,733	33,649			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						26.25
27.00 Total (sum of lines 14-26)				0.00	112.76	27.00
28.00 Observation Bed Days		0	471			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			5			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

Component	Full Time	Discharges			Total All Patients	
	Equivalents	Title V	Title XVIII	Title XIX		
	Nonpaid Workers	11.00	12.00	13.00		
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	205	32	445	1.00
2.00 HMO and other (see instructions)			32			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	205	32	445	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						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: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet S-10 Date/Time Prepared: 11/25/2013 5:37 pm
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.271372	1.00	
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		463,451	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		12,065,268	6.00	
7.00	Medicaid cost (line 1 times line 6)		3,274,176	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)		2,810,725	8.00	
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
<b>Uncompensated care (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		190,173	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,810,725	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility		6,345,376	27,999	6,373,375
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		1,721,957	7,598	1,729,555
22.00	Partial payment by patients approved for charity care		0	0	0
23.00	Cost of charity care (line 21 minus line 22)		1,721,957	7,598	1,729,555
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2,557,370	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			573,111	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)			1,984,259	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			538,472	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			2,268,027	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			5,078,752	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151303

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

worksheet A

Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT		787,050		738,633	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	198,288	1,858,147	2,056,435	2,056,435	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,528,622	2,137,441	3,666,063	3,714,480	5.00
7.00	00700	OPERATION OF PLANT	149,116	593,317	742,433	742,433	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	94,398	94,398	94,398	8.00
9.00	00900	HOUSEKEEPING	0	397,440	397,440	397,440	9.00
10.00	01000	DIETARY	0	245,350	245,350	83,468	10.00
11.00	01100	CAFETERIA	0	0	0	161,882	11.00
13.00	01300	NURSING ADMINISTRATION	189,036	25,542	214,578	214,578	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	67,417	23,548	90,965	90,965	14.00
15.00	01500	PHARMACY	163,069	414,448	577,517	577,517	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	139,472	65,482	204,954	204,954	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,024,999	341,600	1,366,599	1,366,599	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	381,226	450,687	831,913	783,302	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	842,387	1,058,369	1,900,756	1,900,348	54.00
60.00	06000	LABORATORY	5,077	1,214,686	1,219,763	1,219,763	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,706	2,706	2,706	65.00
66.00	06600	PHYSICAL THERAPY	0	240,186	240,186	240,186	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	21,034	21,034	21,034	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,162	2,162	2,162	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,355	12,355	72,714	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	116,254	116,254	116,254	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	1,164,889	876,634	2,041,523	2,030,183	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,853,598	10,978,836	16,832,434	16,832,434	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
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	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	110,038	67,556	177,594	177,594	194.00
194.02	07952	OUTPATIENT CLINICS	3,151	538	3,689	3,689	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.03
194.04	07955	SPN	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	5,966,787	11,046,930	17,013,717	17,013,717	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151303

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

Worksheet A

Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-315,244	423,389	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	243,486	2,299,921	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-116,284	3,598,196	5.00
7.00	00700	OPERATION OF PLANT	-11,899	730,534	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	94,398	8.00
9.00	00900	HOUSEKEEPING	-19,872	377,568	9.00
10.00	01000	DIETARY	-49,012	34,456	10.00
11.00	01100	CAFETERIA	0	161,882	11.00
13.00	01300	NURSING ADMINISTRATION	-450	214,128	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	90,965	14.00
15.00	01500	PHARMACY	0	577,517	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,364	191,590	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-148,624	1,217,975	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	783,302	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-138,195	1,762,153	54.00
60.00	06000	LABORATORY	-13,692	1,206,071	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,706	65.00
66.00	06600	PHYSICAL THERAPY	-9,238	230,948	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	21,034	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,162	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	72,714	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	116,254	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	-441,667	1,588,516	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,034,055	15,798,379	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	177,594	194.00
194.02	07952	OUTPATIENT CLINICS	0	3,689	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	154,047	154,047	194.03
194.04	07955	SPN	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	-880,008	16,133,709	200.00

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	03000		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	05000		50.00
54.00	RADIOLOGY - DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
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
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
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	08800		88.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	19000		190.00
191.00	RESEARCH	19100		191.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	07950		194.00
194.02	OUTPATIENT CLINICS	07952		194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS	07953		194.03
194.04	SPN	07955		194.04
200.00	TOTAL (SUM OF LINES 118-199)			200.00

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
<b>A - CAFETERIA</b>					
1.00	CAFETERIA	11.00	0	161,882	1.00
	TOTALS		0	161,882	
<b>B - INTEREST</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	48,417	1.00
	TOTALS		0	48,417	
<b>C - MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	60,359	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	60,359	
500.00	Grand Total: Increases		0	270,658	500.00

		Decreases				
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
<b>A - CAFETERIA</b>						
1.00	DIETARY	10.00	0	161,882	0	1.00
	TOTALS		0	161,882		
<b>B - INTEREST</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	48,417	9	1.00
	TOTALS		0	48,417		
<b>C - MEDICAL SUPPLIES</b>						
1.00	OPERATING ROOM	50.00	0	48,611	0	1.00
2.00	RADIOLOGY - DIAGNOSTIC	54.00	0	408	0	2.00
3.00	EMERGENCY	91.00	0	11,340	0	3.00
	TOTALS		0	60,359		
500.00	Grand Total: Decreases		0	270,658		500.00

	Increases			Decreases			
	Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	3.00	4.00	6.00	7.00	8.00	
	<b>A - CAFETERIA</b>						
1.00	CAFETERIA	11.00	0	DIETARY	10.00	0	1.00
	TOTALS		0	TOTALS		0	
	<b>B - INTEREST</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
	TOTALS		0	TOTALS		0	
	<b>C - MEDICAL SUPPLIES</b>						
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	OPERATING ROOM	50.00	0	1.00
	PATIENTS						
2.00		0.00	0	RADIOLOGY - DIAGNOSTIC	54.00	0	2.00
3.00		0.00	0	EMERGENCY	91.00	0	3.00
	TOTALS		0	TOTALS		0	
500.00	Grand Total: Increases		0	Grand Total: Decreases		0	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151303

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/25/2013 5:37 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	127,944	0	0	0	1.00
2.00	Land Improvements	400,829	8,950	0	8,950	2.00
3.00	Buildings and Fixtures	13,648,625	0	0	0	3.00
4.00	Building Improvements	0	0	0	4,818	4.00
5.00	Fixed Equipment	4,201,276	0	0	0	5.00
6.00	Movable Equipment	0	3,336,861	0	3,232,991	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,378,674	3,345,811	0	3,237,809	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	18,378,674	3,345,811	0	3,237,809	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	127,944	0			1.00
2.00	Land Improvements	409,779	0			2.00
3.00	Buildings and Fixtures	13,643,807	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	968,285	0			5.00
6.00	Movable Equipment	3,336,861	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	18,486,676	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	18,486,676	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151303

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	CAP REL COSTS-BLDG & FIXT	402,157	0	374,402	10,491	0	1.00
3.00	Total (sum of lines 1-2)	402,157	0	374,402	10,491	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	787,050				1.00
3.00	Total (sum of lines 1-2)	0	787,050				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151303

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	18,486,676	0	18,486,676	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	18,486,676	0	18,486,676	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	175,627	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	175,627	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	237,271	10,491	0	0	423,389	1.00
3.00	Total (sum of lines 1-2)	237,271	10,491	0	0	423,389	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151303

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

Worksheet A-8

Date/Time Prepared:  
11/25/2013 5:37 pm

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Ref.
				Cost Center	Line #	
				3.00	4.00	
		1.00	2.00	3.00	4.00	5.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-178,113	CAP REL COSTS-BLDG & FIXT	1.00	9 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0 2.00
3.00	Investment income - other (chapter 2)	B	-26,453	ADMINISTRATIVE & GENERAL	5.00	0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0 7.00
8.00	Television and radio service (chapter 21)	A	-3,298	OPERATION OF PLANT	7.00	0 8.00
9.00	Parking lot (chapter 21)		0		0.00	0 9.00
10.00	Provider-based physician adjustment	A-8-2	-745,185			0 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,008,133			0 12.00
13.00	Laundry and linen service		0		0.00	0 13.00
14.00	Cafeteria-employees and guests	B	-33,658	DIETARY	10.00	0 14.00
15.00	Rental of quarters to employee and others		0		0.00	0 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0 16.00
17.00	Sale of drugs to other than patients		0		0.00	0 17.00
18.00	Sale of medical records and abstracts	B	-13,364	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	B	-2,546	ADMINISTRATIVE & GENERAL	5.00	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	-9,238	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	*** Cost Center Deleted ***	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			0		0.00	0 33.00
33.01	CHARITABLE EXPENSE	A	-337	EMPLOYEE BENEFITS	4.00	0 33.01

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
33.02 CHARITABLE EXPENSE	A	-5,489	ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03 AHA & IHA DUES	A	-562	ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.04		0		0.00	0 33.04
33.05 DONATION EXPENSE	A	-500	ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.06 DONATION EXPENSE	A	-450	NURSING ADMINISTRATION	13.00	0 33.06
33.07 CHARITABLE EXPENSE	A	-337	EMPLOYEE BENEFITS	4.00	0 33.07
33.08 CHARITABLE EXPENSE	A	-5,489	ADMINISTRATIVE & GENERAL	5.00	0 33.08
33.09 PHYSICIAN HOUSEKEEPING	A	-19,872	HOUSEKEEPING	9.00	0 33.09
33.10 PHYSICIAN PLANT OPS	A	-8,909	OPERATION OF PLANT	7.00	0 33.10
33.11 PHYSICIAN BENEFITS	A	-617	EMPLOYEE BENEFITS	4.00	0 33.11
33.12		0		0.00	0 33.12
33.13 MISC REVENUE	B	-11,477	ADMINISTRATIVE & GENERAL	5.00	0 33.13
33.14 MISC REVENUE	B	-5,732	EMPLOYEE BENEFITS	4.00	0 33.14
33.15 MISC REVENUE	B	-84	RADIOLOGY - DIAGNOSTIC	54.00	0 33.15
33.16 MISC REVENUE	B	-15,354	DIETARY	10.00	0 33.16
33.17 HOSPITAL PROVIDER TAX	A	-800,946	ADMINISTRATIVE & GENERAL	5.00	0 33.17
33.18		0		0.00	0 33.18
33.19 ENTERTAINMENT	A	-131	ADMINISTRATIVE & GENERAL	5.00	0 33.19
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-880,008			50.00

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

Provider CCN: 151303

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

Worksheet A-8-1

Date/Time Prepared: 11/25/2013 5:37 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED</b>					
<b>HOME OFFICE COSTS:</b>					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,942,748	1,035,748
2.00	4.00	EMPLOYEE BENEFITS	HOME OFFICE	0	68,948
3.00	194.03	OTHER NONREIMBURSABLE COST CENTERS	HOME OFFICE	154,047	0
4.00	4.00	EMPLOYEE BENEFITS	ASCENSION CHARGEBACKS	252,277	252,277
4.01	5.00	ADMINISTRATIVE & GENERAL	ASCENSION CHARGEBACKS	701,131	701,131
4.02	7.00	OPERATION OF PLANT	ASCENSION CHARGEBACKS	52,635	52,635
4.03	13.00	NURSING ADMINISTRATION	ASCENSION CHARGEBACKS	250	250
4.04	14.00	CENTRAL SERVICES & SUPPLY	ASCENSION CHARGEBACKS	69,949	69,949
4.05	16.00	MEDICAL RECORDS & LIBRARY	ASCENSION CHARGEBACKS	81,961	81,961
4.06	50.00	OPERATING ROOM	ASCENSION CHARGEBACKS	150	150
4.07	54.00	RADIOLOGY - DIAGNOSTIC	ASCENSION CHARGEBACKS	12,461	12,461
4.08	91.00	EMERGENCY	ASCENSION CHARGEBACKS	19,658	19,658
4.09	4.00	EMPLOYEE BENEFITS	HOME OFFICE SELF-INSURANCE	1,177,226	861,897
4.10	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - EXECUTIVE PAY	0	149,323
4.11	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	188,854	325,985
4.12	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	28,049	48,417
4.13	7.00	OPERATION OF PLANT	TRIMEDX	21,629	21,321
4.14	54.00	RADIOLOGY - DIAGNOSTIC	TRIMEDX	217,093	214,002
4.15	4.00	EMPLOYEE BENEFITS	ASCENSION PENSION	148,259	144,131
4.16	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION PAYMENTS	10,491	10,491
4.17	4.00	EMPLOYEE BENEFITS	ASCENSION PAYMENTS	9,124	9,124
4.18	5.00	ADMINISTRATIVE & GENERAL	ASCENSION PAYMENTS	-31,251	-31,251
4.19	0.00			0	0
4.20	0.00			0	0
4.21	0.00			0	0
4.22	0.00			0	0
5.00	0		0	5,056,741	4,048,608

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

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

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

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

6.00	G	ST. VINCENT HEA	100.00	ST. VINCENT HEA	100.00	6.00
7.00	B	ST. VINCENT HOS	100.00	ST. VINCENT HOS	100.00	7.00
8.00	G	ASCENSION	100.00	ASCENSION	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: 151303

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

Worksheet A-8-1

Date/Time Prepared:  
11/25/2013 5:37 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>			
1.00	907,000	0	1.00
2.00	-68,948	0	2.00
3.00	154,047	0	3.00
4.00	0	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
4.03	0	0	4.03
4.04	0	0	4.04
4.05	0	0	4.05
4.06	0	0	4.06
4.07	0	0	4.07
4.08	0	0	4.08
4.09	315,329	0	4.09
4.10	-149,323	0	4.10
4.11	-137,131	11	4.11
4.12	-20,368	0	4.12
4.13	308	0	4.13
4.14	3,091	0	4.14
4.15	4,128	0	4.15
4.16	0	11	4.16
4.17	0	0	4.17
4.18	0	0	4.18
4.19	0	0	4.19
4.20	0	0	4.20
4.21	0	0	4.21
4.22	0	0	4.22
5.00	1,008,133		5.00

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

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

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

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

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

6.00	ADMINISTRATION	6.00
7.00	HOSPITAL	7.00
8.00	ADMINISTRATION	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: 151303

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

Worksheet A-8-2

Date/Time Prepared:  
11/25/2013 5:37 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	148,624	148,624	0	0	0	1.00
2.00	54.00	RADIOLOGY - DIAGNOSTIC	141,202	141,202	0	0	0	2.00
3.00	60.00	LABORATORY	13,692	13,692	0	0	0	3.00
4.00	91.00	EMERGENCY	1,005,435	441,667	563,768	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,308,953	745,185	563,768			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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	30.00	ADULTS & PEDIATRICS	0	0	0	148,624		1.00
2.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	141,202		2.00
3.00	60.00	LABORATORY	0	0	0	13,692		3.00
4.00	91.00	EMERGENCY	0	0	0	441,667		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	745,185		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2013 5:37 pm
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	Physical Therapy	Cost	
		1.00	

<b>PART I - GENERAL INFORMATION</b>			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52 1.00
2.00	Line 1 multiplied by 15 hours per week		780 2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		196 3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		59 4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0 5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0 6.00
7.00	Standard travel expense rate		5.21 7.00
8.00	Optional travel expense rate per mile		0.00 8.00

	Supervisors	Therapists	Assistants	Aides	Trainees	
	1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,467.01	1,861.90	0.00	0.00 9.00
10.00	AHSEA (see instructions)	0.00	74.92	56.19	0.00	0.00 10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.46	37.46	28.10		
12.00	Number of travel hours (provider site)	0	0	0		12.00
12.01	Number of travel hours (offsite)	0	0	0		12.01
13.00	Number of miles driven (provider site)	0	0	0		13.00
13.01	Number of miles driven (offsite)	0	0	0		13.01

<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0 14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		109,908 15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)		104,620 16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		214,528 17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0 18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0 19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		214,528 20.00
<b>If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. otherwise complete lines 21-23.</b>			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00 21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0 22.00
23.00	Total salary equivalency (see instructions)		214,528 23.00

<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>			
<b>Standard Travel Allowance</b>			
24.00	Therapists (line 3 times column 2, line 11)		7,342 24.00
25.00	Assistants (line 4 times column 3, line 11)		1,658 25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		9,000 26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		1,329 27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		10,329 28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0 29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0 30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0 31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0 32.00
33.00	Standard travel allowance and standard travel expense (line 28)		10,329 33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0 34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0 35.00

<b>PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>			
<b>Standard Travel Expense</b>			
36.00	Therapists (line 5 times column 2, line 11)		0 36.00
37.00	Assistants (line 6 times column 3, line 11)		0 37.00
38.00	Subtotal (sum of lines 36 and 37)		0 38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0 39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0 40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0 41.00
42.00	Subtotal (sum of lines 40 and 41)		0 42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0 43.00
<b>Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.</b>			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0 44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0 45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2013 5:37 pm
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	Physical Therapy	Cost	
		1.00	

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

**PART V - OVERTIME COMPUTATION**

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00

**CALCULATION OF LIMIT**

50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00

**DETERMINATION OF OVERTIME ALLOWANCE**

52.00	Adjusted hourly salary equivalency amount (see instructions)	74.92	56.19	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

						1.00	
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**Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT**

57.00	Salary equivalency amount (from line 23)					214,528	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					10,329	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					224,857	63.00
64.00	Total cost of outside supplier services (from your records)					234,095	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					9,238	65.00

**LINE 33 CALCULATION**

100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					9,000	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,329	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					10,329	100.02

**LINE 34 CALCULATION**

101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,329	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					1,329	101.02

**LINE 35 CALCULATION**

102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151303		Period: From 07/01/2012 To 06/30/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2013 5:37 pm	
		Occupational Therapy		Cost			
				1.00			
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)					47	1.00
2.00	Line 1 multiplied by 15 hours per week					705	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					97	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.21	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	258.36	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	71.02	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	35.51	35.51	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					18,349	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					18,349	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					18,349	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					71.02	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					50,069	22.00
23.00	Total salary equivalency (see instructions)					50,069	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					3,444	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					3,444	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					505	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,949	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12 )					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					3,949	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
<b>Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.</b>							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS  
 Provider CCN: 151303  
 Period: From 07/01/2012 To 06/30/2013  
 Worksheet A-8-3 Parts I-VI  
 Date/Time Prepared: 11/25/2013 5:37 pm

Occupational Therapy Cost

1.00

45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions) 0 45.00  
 46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions) 0 46.00

	Therapists	Assistants	Aides	Trainees	Total	
	1.00	2.00	3.00	4.00	5.00	

**PART V - OVERTIME COMPUTATION**

47.00 Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56) 0.00 0.00 0.00 0.00 0.00 47.00  
 48.00 Overtime rate (see instructions) 0.00 0.00 0.00 0.00 48.00  
 49.00 Total overtime (including base and overtime allowance) (multiply line 47 times line 48) 0.00 0.00 0.00 0.00 49.00

**CALCULATION OF LIMIT**

50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) 0.00 0.00 0.00 0.00 50.00  
 51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) 0.00 0.00 0.00 0.00 51.00

**DETERMINATION OF OVERTIME ALLOWANCE**

52.00 Adjusted hourly salary equivalency amount (see instructions) 71.02 0.00 0.00 0.00 52.00  
 53.00 Overtime cost limitation (line 51 times line 52) 0 0 0 0 53.00  
 54.00 Maximum overtime cost (enter the lesser of line 49 or line 53) 0 0 0 0 54.00  
 55.00 Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52) 0 0 0 0 55.00  
 56.00 Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.) 0 0 0 0 56.00

1.00

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

57.00 Salary equivalency amount (from line 23) 50,069 57.00  
 58.00 Travel allowance and expense - provider site (from lines 33, 34, or 35) 3,949 58.00  
 59.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 0 59.00  
 60.00 Overtime allowance (from column 5, line 56) 0 60.00  
 61.00 Equipment cost (see instructions) 0 61.00  
 62.00 Supplies (see instructions) 0 62.00  
 63.00 Total allowance (sum of lines 57-62) 54,018 63.00  
 64.00 Total cost of outside supplier services (from your records) 21,034 64.00  
 65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) 0 65.00

**LINE 33 CALCULATION**

100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 3,444 100.00  
 100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 505 100.01  
 100.02 Line 33 = line 28 = sum of lines 26 and 27 3,949 100.02

**LINE 34 CALCULATION**

101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 505 101.00  
 101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 0 101.01  
 101.02 Line 34 = sum of lines 27 and 31 505 101.02

**LINE 35 CALCULATION**

102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 0 102.00  
 102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others 0 102.01  
 102.02 Line 35 = sum of lines 31 and 32 0 102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2013 5:37 pm
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	Speech Pathology	Cost	
		1.00	

<b>PART I - GENERAL INFORMATION</b>			
1.00	Total number of weeks worked (excluding aides) (see instructions)		21 1.00
2.00	Line 1 multiplied by 15 hours per week		315 2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		21 3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0 4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0 5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0 6.00
7.00	Standard travel expense rate		5.21 7.00
8.00	Optional travel expense rate per mile		0.00 8.00

	Supervisors	Therapists	Assistants	Aides	Trainees	
	1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	31.62	0.00	0.00	0.00 9.00
10.00	AHSEA (see instructions)	0.00	68.26	0.00	0.00	0.00 10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.13	34.13	0.00		
12.00	Number of travel hours (provider site)	0	0	0		12.00
12.01	Number of travel hours (offsite)	0	0	0		12.01
13.00	Number of miles driven (provider site)	0	0	0		13.00
13.01	Number of miles driven (offsite)	0	0	0		13.01

						1.00
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<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0 14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		2,158 15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)		0 16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		2,158 17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0 18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0 19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		2,158 20.00
<b>If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.</b>			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		68.25 21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		21,499 22.00
23.00	Total salary equivalency (see instructions)		21,499 23.00

<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>			
<b>Standard Travel Allowance</b>			
24.00	Therapists (line 3 times column 2, line 11)		717 24.00
25.00	Assistants (line 4 times column 3, line 11)		0 25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		717 26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		109 27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		826 28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0 29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0 30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0 31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0 32.00
33.00	Standard travel allowance and standard travel expense (line 28)		826 33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0 34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0 35.00

<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>			
<b>Standard Travel Expense</b>			
36.00	Therapists (line 5 times column 2, line 11)		0 36.00
37.00	Assistants (line 6 times column 3, line 11)		0 37.00
38.00	Subtotal (sum of lines 36 and 37)		0 38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0 39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0 40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0 41.00
42.00	Subtotal (sum of lines 40 and 41)		0 42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0 43.00
<b>Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.</b>			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0 44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0 45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2013 5:37 pm
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	Speech Pathology	Cost
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		1.00	
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46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00
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		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	

**PART V - OVERTIME COMPUTATION**

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
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48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
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49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
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**CALCULATION OF LIMIT**

50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
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51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
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**DETERMINATION OF OVERTIME ALLOWANCE**

52.00	Adjusted hourly salary equivalency amount (see instructions)	68.26	0.00	0.00	0.00	0.00	52.00
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53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
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54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00
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55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00
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56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) ( Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
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						1.00	
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**Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT**

57.00	Salary equivalency amount (from line 23)					21,499	57.00
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58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					826	58.00
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59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
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60.00	Overtime allowance (from column 5, line 56)					0	60.00
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61.00	Equipment cost (see instructions)					0	61.00
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62.00	Supplies (see instructions)					0	62.00
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63.00	Total allowance (sum of lines 57-62)					22,325	63.00
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64.00	Total cost of outside supplier services (from your records)					2,162	64.00
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65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
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**LINE 33 CALCULATION**

100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					717	100.00
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100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					109	100.01
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100.02	Line 33 = line 28 = sum of lines 26 and 27					826	100.02
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**LINE 34 CALCULATION**

101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					109	101.00
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101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
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101.02	Line 34 = sum of lines 27 and 31					109	101.02
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**LINE 35 CALCULATION**

102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
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102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
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102.02	Line 35 = sum of lines 31 and 32					0	102.02
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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151303

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT				
	0	1.00	4.00	4A	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	CAP REL COSTS-BLDG & FIXT	423,389	423,389		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,299,921	0	2,299,921	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,598,196	37,404	609,467	5.00
7.00	00700	OPERATION OF PLANT	730,534	38,651	59,453	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	94,398	460	0	8.00
9.00	00900	HOUSEKEEPING	377,568	8,690	0	9.00
10.00	01000	DIETARY	34,456	4,284	0	10.00
11.00	01100	CAFETERIA	161,882	8,829	0	11.00
13.00	01300	NURSING ADMINISTRATION	214,128	1,005	75,369	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	90,965	7,044	26,879	14.00
15.00	01500	PHARMACY	577,517	3,964	65,016	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	191,590	33,531	55,608	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	1,217,975	39,722	408,671	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	783,302	31,564	151,996	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,762,153	25,579	335,863	54.00
60.00	06000	LABORATORY	1,206,071	10,669	2,024	60.00
65.00	06500	RESPIRATORY THERAPY	2,706	0	0	65.00
66.00	06600	PHYSICAL THERAPY	230,948	10,239	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,034	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,162	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	72,714	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	116,254	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
91.00	09100	EMERGENCY	1,588,516	25,549	464,446	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,798,379	287,184	2,254,792	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,191	0	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,787	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	177,594	0	43,873	194.00
194.02	07952	OUTPATIENT CLINICS	3,689	45,023	1,256	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	154,047	0	0	194.03
194.04	07955	SPN	0	84,204	0	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	16,133,709	423,389	2,299,921	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151303

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	1,124,519				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,489	130,218			8.00
9.00	00900	HOUSEKEEPING	28,134	44,699	597,012		9.00
10.00	01000	DIETARY	13,871	174	10,503	77,121	10.00
11.00	01100	CAFETERIA	28,585	0	0	0	260,252
13.00	01300	NURSING ADMINISTRATION	3,252	0	0	0	6,884
14.00	01400	CENTRAL SERVICES & SUPPLY	22,805	0	0	0	6,405
15.00	01500	PHARMACY	12,833	0	7,159	0	7,019
16.00	01600	MEDICAL RECORDS & LIBRARY	108,559	0	7,628	0	13,714
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	128,602	20,613	114,186	77,121	68,297
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	102,192	26,972	28,664	0	27,668
54.00	05400	RADIOLOGY - DIAGNOSTIC	82,815	13,407	28,458	0	52,649
60.00	06000	LABORATORY	34,541	0	36,116	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	33,150	7,394	11,295	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	82,717	12,416	128,885	0	61,506
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	683,545	125,675	372,894	77,121	244,142
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	7,092	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,497	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	21,300	0	15,701
194.02	07952	OUTPATIENT CLINICS	145,764	4,543	41,485	0	409
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.04	07955	SPN	272,621	0	161,333	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,124,519	130,218	597,012	77,121	260,252

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151303

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
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	404,367					13.00
14.00	01400	0	198,692				14.00
15.00	01500	0	70	904,422			15.00
16.00	01600	0	17	0	510,887		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	245,791	15,808	0	30,046	2,961,840	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	31,715	131,613	0	55,974	1,716,896	50.00
54.00	05400	31,715	14,471	0	174,624	3,280,005	54.00
60.00	06000	15,858	94	0	106,001	1,846,557	60.00
65.00	06500	0	1,282	0	2,258	7,212	65.00
66.00	06600	0	1,206	0	10,263	390,615	66.00
67.00	06700	0	0	0	1,155	29,700	67.00
68.00	06800	0	0	0	91	3,025	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	98,678	71.00
72.00	07200	0	0	0	0	157,765	72.00
73.00	07300	0	0	904,422	0	904,422	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	79,288	33,914	0	130,475	3,349,884	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		404,367	198,475	904,422	510,887	14,746,599	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	10,065	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	21,993	192.00
194.00	07950	0	145	0	0	337,692	194.00
194.02	07952	0	72	0	0	260,083	194.02
194.03	07953	0	0	0	0	209,052	194.03
194.04	07955	0	0	0	0	548,225	194.04
200.00						0	200.00
201.00						0	201.00
202.00		404,367	198,692	904,422	510,887	16,133,709	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151303

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

Worksheet B  
Part 1  
Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	2,961,840
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	1,716,896
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	3,280,005
60.00	06000	LABORATORY	0	1,846,557
65.00	06500	RESPIRATORY THERAPY	0	7,212
66.00	06600	PHYSICAL THERAPY	0	390,615
67.00	06700	OCCUPATIONAL THERAPY	0	29,700
68.00	06800	SPEECH PATHOLOGY	0	3,025
69.00	06900	ELECTROCARDIOLOGY	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	98,678
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	157,765
73.00	07300	DRUGS CHARGED TO PATIENTS	0	904,422
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	RURAL HEALTH CLINIC	0	0
91.00	09100	EMERGENCY	0	3,349,884
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	14,746,599
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	10,065
191.00	19100	RESEARCH	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	21,993
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	337,692
194.02	07952	OUTPATIENT CLINICS	0	260,083
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	209,052
194.04	07955	SPN	0	548,225
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	16,133,709

Provider CCN: 151303

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

Worksheet Non-CMS W  
 Date/Time Prepared:  
 11/25/2013 5:37 pm

Cost Center Description	Statistics Code	Statistics Description	
	1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00 CAP REL COSTS-BLDG & FIXT	1		1.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	5		4.00
5.00 ADMINISTRATIVE & GENERAL	-5		5.00
7.00 OPERATION OF PLANT	1		7.00
8.00 LAUNDRY & LINEN SERVICE	8		8.00
9.00 HOUSEKEEPING	9		9.00
10.00 DIETARY	10		10.00
11.00 CAFETERIA	11		11.00
13.00 NURSING ADMINISTRATION	13		13.00
14.00 CENTRAL SERVICES & SUPPLY	14		14.00
15.00 PHARMACY	15		15.00
16.00 MEDICAL RECORDS & LIBRARY	16		16.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		0	1.00	2A	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
4.00	00400	3,414	0	3,414	3,414		4.00
5.00	00500	235,944	37,404	273,348	902	274,250	5.00
7.00	00700	2,471	38,651	41,122	88	19,115	7.00
8.00	00800	0	460	460	0	2,188	8.00
9.00	00900	270	8,690	8,960	0	8,910	9.00
10.00	01000	667	4,284	4,951	0	894	10.00
11.00	01100	0	8,829	8,829	0	3,938	11.00
13.00	01300	3,081	1,005	4,086	112	6,701	13.00
14.00	01400	0	7,044	7,044	40	2,881	14.00
15.00	01500	1,774	3,964	5,738	97	14,913	15.00
16.00	01600	0	33,531	33,531	83	6,476	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	14,021	39,722	53,743	607	38,440	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	27,668	31,564	59,232	226	22,304	50.00
54.00	05400	20,281	25,579	45,860	499	48,990	54.00
60.00	06000	0	10,669	10,669	3	28,114	60.00
65.00	06500	0	0	0	0	62	65.00
66.00	06600	1,001	10,239	11,240	0	5,564	66.00
67.00	06700	0	0	0	0	485	67.00
68.00	06800	0	0	0	0	50	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	1,677	71.00
72.00	07200	0	0	0	0	2,682	72.00
73.00	07300	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	6,250	25,549	31,799	690	47,947	91.00
92.00	09200			0			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		316,842	287,184	604,026	3,347	262,331	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	2,191	2,191	0	51	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	4,787	4,787	0	110	192.00
194.00	07950	0	0	0	65	5,109	194.00
194.02	07952	106	45,023	45,129	2	1,153	194.02
194.03	07953	0	0	0	0	3,554	194.03
194.04	07955	0	84,204	84,204	0	1,942	194.04
200.00				0			200.00
201.00				0		0	201.00
202.00		316,948	423,389	740,337	3,414	274,250	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	60,325				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	80	2,728			8.00	
9.00	00900	HOUSEKEEPING	1,509	936	20,315		9.00	
10.00	01000	DIETARY	744	4	357	6,950	10.00	
11.00	01100	CAFETERIA	1,533	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	174	0	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	1,223	0	0	0	14.00	
15.00	01500	PHARMACY	688	0	244	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	5,824	0	260	0	16.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	6,899	432	3,885	6,950	3,752	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	5,482	565	975	0	1,520	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	4,443	281	968	0	2,893	54.00
60.00	06000	LABORATORY	1,853	0	1,229	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,778	155	384	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	4,437	260	4,386	0	3,380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,667	2,633	12,688	6,950	13,415	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	380	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	831	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	725	0	863	194.00
194.02	07952	OUTPATIENT CLINICS	7,820	95	1,412	0	22	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07955	SPN	14,627	0	5,490	0	0	194.04
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)	60,325	2,728	20,315	6,950	14,300	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
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	11,451					13.00
14.00	01400	0	11,540				14.00
15.00	01500	0	4	22,070			15.00
16.00	01600	0	1	0	46,929		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	6,961	918	0	2,761	125,348	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	898	7,646	0	5,143	103,991	50.00
54.00	05400	898	840	0	16,034	121,706	54.00
60.00	06000	449	5	0	9,739	52,061	60.00
65.00	06500	0	74	0	207	343	65.00
66.00	06600	0	70	0	943	20,134	66.00
67.00	06700	0	0	0	106	591	67.00
68.00	06800	0	0	0	8	58	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	1,677	71.00
72.00	07200	0	0	0	0	2,682	72.00
73.00	07300	0	0	22,070	0	22,070	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	2,245	1,970	0	11,988	109,102	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		11,451	11,528	22,070	46,929	559,763	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	2,622	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	5,728	192.00
194.00	07950	0	8	0	0	6,770	194.00
194.02	07952	0	4	0	0	55,637	194.02
194.03	07953	0	0	0	0	3,554	194.03
194.04	07955	0	0	0	0	106,263	194.04
200.00						0	200.00
201.00		0	0	0	0	0	201.00
202.00		11,451	11,540	22,070	46,929	740,337	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	125,348
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	103,991
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	121,706
60.00	06000	LABORATORY	0	52,061
65.00	06500	RESPIRATORY THERAPY	0	343
66.00	06600	PHYSICAL THERAPY	0	20,134
67.00	06700	OCCUPATIONAL THERAPY	0	591
68.00	06800	SPEECH PATHOLOGY	0	58
69.00	06900	ELECTROCARDIOLOGY	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,677
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	2,682
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,070
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	RURAL HEALTH CLINIC	0	0
91.00	09100	EMERGENCY	0	109,102
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	559,763
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,622
191.00	19100	RESEARCH	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,728
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	6,770
194.02	07952	OUTPATIENT CLINICS	0	55,637
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	3,554
194.04	07955	SPN	0	106,263
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	740,337

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151303

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

Worksheet B-1

Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQURE FEET)	
	BLDG & FIXT (SQURE FEET)					
	1.00	4.00	5A	5.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	69,965				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,768,499			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,181	1,528,622	-4,245,067	11,888,642	5.00
7.00 00700	OPERATION OF PLANT	6,387	149,116	0	828,638	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	76	0	0	94,858	8.00
9.00 00900	HOUSEKEEPING	1,436	0	0	386,258	9.00
10.00 01000	DIETARY	708	0	0	38,740	10.00
11.00 01100	CAFETERIA	1,459	0	0	170,711	11.00
13.00 01300	NURSING ADMINISTRATION	166	189,036	0	290,502	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,164	67,417	0	124,888	14.00
15.00 01500	PHARMACY	655	163,069	0	646,497	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	5,541	139,472	0	280,729	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	6,564	1,024,999	0	1,666,368	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	5,216	381,226	0	966,862	50.00
54.00 05400	RADIOLOGY - DIAGNOSTIC	4,227	842,387	0	2,123,595	54.00
60.00 06000	LABORATORY	1,763	5,077	0	1,218,764	60.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	2,706	65.00
66.00 06600	PHYSICAL THERAPY	1,692	0	0	241,187	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	21,034	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	2,162	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	72,714	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	116,254	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00 09100	EMERGENCY	4,222	1,164,889	0	2,078,511	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	47,457	5,655,310	-4,245,067	11,371,978	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	362	0	0	2,191	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	791	0	0	4,787	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	110,038	0	221,467	194.00
194.02 07952	OUTPATIENT CLINICS	7,440	3,151	0	49,968	194.02
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	154,047	194.03
194.04 07955	SPN	13,915	0	0	84,204	194.04
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)	423,389	2,299,921		4,245,067	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	6.051440	0.398704		0.357069	203.00
204.00	Cost to be allocated (per wkst. B, Part II)		3,414		274,250	204.00
205.00	Unit cost multiplier (wkst. B, Part II)		0.000592		0.023068	205.00

Cost Center Description		LAUNDRY & LINEN SERVICE (ITEMIZED BILLS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
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	94,399				8.00
9.00	00900	HOUSEKEEPING	32,404	20,349			9.00
10.00	01000	DIETARY	126	358	100		10.00
11.00	01100	CAFETERIA	0	0	0	156,030	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	4,127	102 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	3,840	0 14.00
15.00	01500	PHARMACY	0	244	0	4,208	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	260	0	8,222	0 16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	14,943	3,892	100	40,947	62 30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	19,553	977	0	16,588	8 50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	9,719	970	0	31,565	8 54.00
60.00	06000	LABORATORY	0	1,231	0	0	4 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	5,360	385	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
91.00	09100	EMERGENCY	9,001	4,393	0	36,875	20 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	91,106	12,710	100	146,372	102 118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
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	0	0	0	0	0 192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	726	0	9,413	0 194.00
194.02	07952	OUTPATIENT CLINICS	3,293	1,414	0	245	0 194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.03
194.04	07955	SPN	0	5,499	0	0	0 194.04
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)	130,218	597,012	77,121	260,252	404,367 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.379443	29.338641	771.210000	1.667961	3,964.382353 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,728	20,315	6,950	14,300	11,451 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.028899	0.998329	69.500000	0.091649	112.264706 205.00

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
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	451,870		14.00
15.00	01500	PHARMACY	160	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	39	0	16.00
				49,990,415	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	35,950	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	299,319	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	32,910	0	54.00
60.00	06000	LABORATORY	214	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,915	0	65.00
66.00	06600	PHYSICAL THERAPY	2,743	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	77,127	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	451,377	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	330	0	194.00
194.02	07952	OUTPATIENT CLINICS	163	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.03
194.04	07955	SPN	0	0	194.04
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)	198,692	904,422	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	0.439711	9,044.220000	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	11,540	22,070	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.025538	220.700000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151303

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/25/2013 5:37 pm

		Title XVIII		Hospital		Cost	
Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	2,961,840		2,961,840	0	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,716,896		1,716,896	0	0	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	3,280,005		3,280,005	0	0	54.00
60.00	06000 LABORATORY	1,846,557		1,846,557	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	7,212	0	7,212	0	0	65.00
66.00	06600 PHYSICAL THERAPY	390,615	0	390,615	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	29,700	0	29,700	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	3,025	0	3,025	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	98,678		98,678	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	157,765		157,765	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	904,422		904,422	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
91.00	09100 EMERGENCY	3,349,884		3,349,884	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	700,339		700,339	0	0	92.00
200.00	Subtotal (see instructions)	15,446,938	0	15,446,938	0	0	200.00
201.00	Less Observation Beds	700,339		700,339	0	0	201.00
202.00	Total (see instructions)	14,746,599	0	14,746,599	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151303

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/25/2013 5:37 pm

		Title XVIII			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,741,700		1,741,700		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	86,600	5,390,350	5,476,950	0.313477	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	609,689	16,478,285	17,087,974	0.191948	54.00
60.00	06000	LABORATORY	694,307	9,677,569	10,371,876	0.178035	60.00
65.00	06500	RESPIRATORY THERAPY	186,922	34,026	220,948	0.032641	65.00
66.00	06600	PHYSICAL THERAPY	134,458	869,733	1,004,191	0.388985	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,273	64,737	113,010	0.262809	67.00
68.00	06800	SPEECH PATHOLOGY	2,383	6,481	8,864	0.341268	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	412,641	773,541	1,186,182	0.083190	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,064	432,657	435,721	0.362078	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,091,601	1,637,070	2,728,671	0.331451	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	324,591	12,442,059	12,766,650	0.262393	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	243,769	954,483	1,198,252	0.584467	92.00
200.00		Subtotal (see instructions)	5,579,998	48,760,991	54,340,989		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,579,998	48,760,991	54,340,989		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151303

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC				88.00
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: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet C Part I Date/Time Prepared: 11/25/2013 5:37 pm
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Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
			Total Costs	RCE Disallowance		
			3.00	4.00		
<b>Title XIX Hospital PPS</b>						
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	2,961,840		2,961,840	0	2,961,840	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	1,716,896		1,716,896	0	1,716,896	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	3,280,005		3,280,005	0	3,280,005	54.00
60.00 06000 LABORATORY	1,846,557		1,846,557	0	1,846,557	60.00
65.00 06500 RESPIRATORY THERAPY	7,212	0	7,212	0	7,212	65.00
66.00 06600 PHYSICAL THERAPY	390,615	9,238	399,853	0	399,853	66.00
67.00 06700 OCCUPATIONAL THERAPY	29,700	0	29,700	0	29,700	67.00
68.00 06800 SPEECH PATHOLOGY	3,025	0	3,025	0	3,025	68.00
69.00 06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	98,678		98,678	0	98,678	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	157,765		157,765	0	157,765	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	904,422		904,422	0	904,422	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
91.00 09100 EMERGENCY	3,349,884		3,349,884	0	3,349,884	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	700,339		700,339	0	700,339	92.00
200.00 Subtotal (see instructions)	15,446,938	0	15,456,176	0	15,456,176	200.00
201.00 Less Observation Beds	700,339		700,339		700,339	201.00
202.00 Total (see instructions)	14,746,599	0	14,755,837	0	14,755,837	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151303

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/25/2013 5:37 pm

		Title XIX			Hospital	PPS		
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				
		9.00	10.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,741,700		1,741,700			30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	86,600	5,390,350	5,476,950	0.313477	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	609,689	16,478,285	17,087,974	0.191948	0.000000	54.00
60.00	06000	LABORATORY	694,307	9,677,569	10,371,876	0.178035	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	186,922	34,026	220,948	0.032641	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	134,458	869,733	1,004,191	0.388985	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,273	64,737	113,010	0.262809	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,383	6,481	8,864	0.341268	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	412,641	773,541	1,186,182	0.083190	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,064	432,657	435,721	0.362078	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,091,601	1,637,070	2,728,671	0.331451	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
91.00	09100	EMERGENCY	324,591	12,442,059	12,766,650	0.262393	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	243,769	954,483	1,198,252	0.584467	0.000000	92.00
200.00		Subtotal (see instructions)	5,579,998	48,760,991	54,340,989			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,579,998	48,760,991	54,340,989			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151303

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.313477			50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.191948			54.00
60.00	06000 LABORATORY	0.178035			60.00
65.00	06500 RESPIRATORY THERAPY	0.032641			65.00
66.00	06600 PHYSICAL THERAPY	0.398184			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.262809			67.00
68.00	06800 SPEECH PATHOLOGY	0.341268			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083190			71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.362078			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.331451			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
91.00	09100 EMERGENCY	0.262393			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.584467			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 151303

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

Worksheet C  
Part II  
Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (wkst. B, Part I, col. 26)	Capital Cost (wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,716,896	103,991	1,612,905	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	3,280,005	121,706	3,158,299	0	0	54.00
60.00	06000	LABORATORY	1,846,557	52,061	1,794,496	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,212	343	6,869	0	0	65.00
66.00	06600	PHYSICAL THERAPY	390,615	20,134	370,481	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,700	591	29,109	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,025	58	2,967	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	98,678	1,677	97,001	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	157,765	2,682	155,083	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	904,422	22,070	882,352	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	3,349,884	109,102	3,240,782	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	700,339	0	700,339	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	12,485,098	434,415	12,050,683	0	0	200.00
201.00		Less Observation Beds	700,339	0	700,339	0	0	201.00
202.00		Total (line 200 minus line 201)	11,784,759	434,415	11,350,344	0	0	202.00

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

Provider CCN: 151303

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

Worksheet C  
Part II  
Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	1,716,896	5,476,950	0.313477		50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	3,280,005	17,087,974	0.191948		54.00
60.00	06000 LABORATORY	1,846,557	10,371,876	0.178035		60.00
65.00	06500 RESPIRATORY THERAPY	7,212	220,948	0.032641		65.00
66.00	06600 PHYSICAL THERAPY	390,615	1,004,191	0.388985		66.00
67.00	06700 OCCUPATIONAL THERAPY	29,700	113,010	0.262809		67.00
68.00	06800 SPEECH PATHOLOGY	3,025	8,864	0.341268		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	98,678	1,186,182	0.083190		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	157,765	435,721	0.362078		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	904,422	2,728,671	0.331451		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000		88.00
91.00	09100 EMERGENCY	3,349,884	12,766,650	0.262393		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	700,339	1,198,252	0.584467		92.00
200.00	Subtotal (sum of lines 50 thru 199)	12,485,098	52,599,289			200.00
201.00	Less Observation Beds	700,339	0			201.00
202.00	Total (line 200 minus line 201)	11,784,759	52,599,289			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151303		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part II Date/Time Prepared: 11/25/2013 5:37 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	103,991	5,476,950	0.018987	23,689	450	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	121,706	17,087,974	0.007122	101,451	723	54.00
60.00	06000 LABORATORY	52,061	10,371,876	0.005019	354,652	1,780	60.00
65.00	06500 RESPIRATORY THERAPY	343	220,948	0.001552	97,535	151	65.00
66.00	06600 PHYSICAL THERAPY	20,134	1,004,191	0.020050	31,688	635	66.00
67.00	06700 OCCUPATIONAL THERAPY	591	113,010	0.005230	9,163	48	67.00
68.00	06800 SPEECH PATHOLOGY	58	8,864	0.006543	1,077	7	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,677	1,186,182	0.001414	157,628	223	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	2,682	435,721	0.006155	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	22,070	2,728,671	0.008088	483,145	3,908	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
91.00	09100 EMERGENCY	109,102	12,766,650	0.008546	1,102	9	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,198,252	0.000000	10,989	0	92.00
200.00	Total (lines 50-199)	434,415	52,599,289		1,272,119	7,934	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151303		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part IV Date/Time Prepared: 11/25/2013 5:37 pm		
Cost Center Description		Title XVIII			Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 151303

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	5,476,950	0.000000	0.000000	23,689	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	17,087,974	0.000000	0.000000	101,451	54.00
60.00	06000 LABORATORY	0	10,371,876	0.000000	0.000000	354,652	60.00
65.00	06500 RESPIRATORY THERAPY	0	220,948	0.000000	0.000000	97,535	65.00
66.00	06600 PHYSICAL THERAPY	0	1,004,191	0.000000	0.000000	31,688	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	113,010	0.000000	0.000000	9,163	67.00
68.00	06800 SPEECH PATHOLOGY	0	8,864	0.000000	0.000000	1,077	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,186,182	0.000000	0.000000	157,628	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	435,721	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,728,671	0.000000	0.000000	483,145	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
91.00	09100 EMERGENCY	0	12,766,650	0.000000	0.000000	1,102	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,198,252	0.000000	0.000000	10,989	92.00
200.00	Total (lines 50-199)	0	52,599,289			1,272,119	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151303		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part IV Date/Time Prepared: 11/25/2013 5:37 pm	
Cost Center Description		Title XVIII			Hospital		Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/25/2013 5:37 pm
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
<b>ANCILLARY SERVICE COST CENTERS</b>		23.00	24.00			
50.00	05000 OPERATING ROOM	0	0			50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	0			54.00
60.00	06000 LABORATORY	0	0			60.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0			88.00
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: 151303

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

Worksheet D  
Part V  
Date/Time Prepared:  
11/25/2013 5:37 pm

		Title XVIII		Hospital		Cost		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.313477	0	1,454,718	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.191948	0	3,793,913	0	0	54.00
60.00	06000	LABORATORY	0.178035	0	3,394,141	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.032641	0	11,351	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.388985	0	247,666	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.262809	0	26,746	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.341268	0	2,954	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083190	0	299,319	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.362078	0	130,727	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331451	0	590,138	9,553	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.262393	0	2,863,782	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.584467	0	236,648	0	0	92.00
200.00		Subtotal (see instructions)		0	13,052,103	9,553	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	13,052,103	9,553	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151303

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

Worksheet D  
Part V  
Date/Time Prepared:  
11/25/2013 5:37 pm

		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			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	456,021	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	728,234	0	54.00
60.00	06000	LABORATORY	604,276	0	60.00
65.00	06500	RESPIRATORY THERAPY	371	0	65.00
66.00	06600	PHYSICAL THERAPY	96,338	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,029	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,008	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,900	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	47,333	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	195,602	3,166	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	751,436	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	138,313	0	92.00
200.00		Subtotal (see instructions)	3,050,861	3,166	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	3,050,861	3,166	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151303 Component CCN: 152303	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/25/2013 5:37 pm
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.313477	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.191948	0	0	0	0	54.00
60.00	06000	LABORATORY	0.178035	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.032641	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.388985	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.262809	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.341268	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083190	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.362078	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331451	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
91.00	09100	EMERGENCY	0.262393	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.584467	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: 151303

Period:  
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To 06/30/2013

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Component CCN: 152303

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
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: 151303		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part I Date/Time Prepared: 11/25/2013 5:37 pm	
Title XIX			Hospital		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	125,348	20,020	105,328	1,673	62.96	30.00
200.00	Total (lines 30-199)	125,348		105,328	1,673		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	102	6,422				
200.00	Total (lines 30-199)	102	6,422				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part II Date/Time Prepared: 11/25/2013 5:37 pm		
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Title XIX			
				Hospital Inpatient Program Charges	PPS Capital Costs (column 3 x column 4)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	103,991	5,476,950	0.018987	30,547	580	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	121,706	17,087,974	0.007122	129,064	919	54.00
60.00	06000 LABORATORY	52,061	10,371,876	0.005019	140,473	705	60.00
65.00	06500 RESPIRATORY THERAPY	343	220,948	0.001552	0	0	65.00
66.00	06600 PHYSICAL THERAPY	20,134	1,004,191	0.020050	941	19	66.00
67.00	06700 OCCUPATIONAL THERAPY	591	113,010	0.005230	256	1	67.00
68.00	06800 SPEECH PATHOLOGY	58	8,864	0.006543	338	2	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,677	1,186,182	0.001414	44,536	63	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	2,682	435,721	0.006155	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	22,070	2,728,671	0.008088	179,374	1,451	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
91.00	09100 EMERGENCY	109,102	12,766,650	0.008546	135,332	1,157	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	35,289	1,198,252	0.029450	0	0	92.00
200.00	Total (lines 50-199)	469,704	52,599,289		660,861	4,897	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151303		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part III Date/Time Prepared: 11/25/2013 5:37 pm	
Cost Center Description			Title XIX			Hospital		PPS
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,673	0.00	102	0	0	30.00
200.00		Total (lines 30-199)	1,673		102	0	0	200.00
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
			12.00	13.00				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
200.00		Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303

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Cost Center Description		Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/25/2013 5:37 pm			
Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	5,476,950	0.000000	0.000000	30,547	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	17,087,974	0.000000	0.000000	129,064	54.00
60.00	06000 LABORATORY	0	10,371,876	0.000000	0.000000	140,473	60.00
65.00	06500 RESPIRATORY THERAPY	0	220,948	0.000000	0.000000	0	65.00
66.00	06600 PHYSICAL THERAPY	0	1,004,191	0.000000	0.000000	941	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	113,010	0.000000	0.000000	256	67.00
68.00	06800 SPEECH PATHOLOGY	0	8,864	0.000000	0.000000	338	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,186,182	0.000000	0.000000	44,536	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	435,721	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,728,671	0.000000	0.000000	179,374	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
91.00	09100 EMERGENCY	0	12,766,650	0.000000	0.000000	135,332	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,198,252	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	52,599,289			660,861	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303

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Cost Center Description		Title XIX			Hospital	PPS	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 151303

Period:  
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		Title XIX	Hospital	PPS
		23.00	24.00				
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0			50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0			54.00
60.00	06000	LABORATORY	0	0			60.00
65.00	06500	RESPIRATORY THERAPY	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	0			69.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0			88.00
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: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/25/2013 5:37 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,002 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,673 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,202 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			159 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)			159 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			6 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)			5 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			667 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)			159 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)			159 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		126.36	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		126.36	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,961,840	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)		758	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)		632	25.00
26.00	Total swing-bed cost (see instructions)		474,231	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,487,609	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,487,609	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,486.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		991,776	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)		991,776	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/25/2013 5:37 pm			
Cost Center Description		Title XVIII		Hospital	Cost		
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
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)					288,289	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,280,065	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and II)						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
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00	Program discharges						0
55.00	Target amount per discharge					0.00	54.00
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	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
62.00	Relief payment (see instructions)						0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					236,420	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					236,420	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					472,840	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
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00	Total observation bed days (see instructions)					471	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,486.92	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					700,339	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151303

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

Worksheet D-1  
Date/Time Prepared:  
11/25/2013 5:37 pm

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	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
90.00	Capital-related cost	0	0	0.000000	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	91.00
92.00	Allied health cost	0	0	0.000000	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/25/2013 5:37 pm
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,002	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,673	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,202	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		318	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		6	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)		5	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		102	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		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)		2,961,840	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)		473,060	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,488,780	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,488,780	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,487.62	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		151,737	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)		151,737	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/25/2013 5:37 pm		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
<b>Intensive Care Type Inpatient Hospital Units</b>						
43.00	INTENSIVE CARE UNIT					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)					158,585 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					310,322 49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					6,422 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					4,897 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					11,319 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					299,003 53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
87.00	Total observation bed days (see instructions)					471 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,487.62 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					700,669 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151303

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

Worksheet D-1

Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description	Cost	Title XIX		Hospital	PPS	
		Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
90.00 Capital-related cost	125,348	2,488,780	0.050365	700,669	35,289	90.00
91.00 Nursing School cost	0	2,488,780	0.000000	700,669	0	91.00
92.00 Allied health cost	0	2,488,780	0.000000	700,669	0	92.00
93.00 All other Medical Education	0	2,488,780	0.000000	700,669	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/25/2013 5:37 pm	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		688,574	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.313477	23,689	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.191948	101,451	54.00
60.00	06000	LABORATORY	0.178035	354,652	60.00
65.00	06500	RESPIRATORY THERAPY	0.032641	97,535	65.00
66.00	06600	PHYSICAL THERAPY	0.388985	31,688	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.262809	9,163	67.00
68.00	06800	SPEECH PATHOLOGY	0.341268	1,077	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083190	157,628	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.362078	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331451	483,145	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100	EMERGENCY	0.262393	1,102	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.584467	10,989	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,272,119	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,272,119	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151303

Period:

Worksheet D-3

Component CCN: 152303

From 07/01/2012

Date/Time Prepared:

To 06/30/2013

11/25/2013 5:37 pm

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS			0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.313477	0	0	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.191948	22,281	4,277	54.00
60.00	06000 LABORATORY	0.178035	27,210	4,844	60.00
65.00	06500 RESPIRATORY THERAPY	0.032641	35,567	1,161	65.00
66.00	06600 PHYSICAL THERAPY	0.388985	86,688	33,720	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.262809	36,926	9,704	67.00
68.00	06800 SPEECH PATHOLOGY	0.341268	679	232	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083190	41,481	3,451	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.362078	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.331451	110,255	36,544	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.262393	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.584467	510	298	92.00
200.00	Total (sum of lines 50-94 and 96-98)		361,597	94,231	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		361,597		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/25/2013 5:37 pm	
Cost Center Description		Title XIX Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		325,233		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.313477	30,547	9,576	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.191948	129,064	24,774	54.00
60.00	06000 LABORATORY	0.178035	140,473	25,009	60.00
65.00	06500 RESPIRATORY THERAPY	0.032641	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.398184	941	375	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.262809	256	67	67.00
68.00	06800 SPEECH PATHOLOGY	0.341268	338	115	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083190	44,536	3,705	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.362078	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.331451	179,374	59,454	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
91.00	09100 EMERGENCY	0.262393	135,332	35,510	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.584467	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		660,861	158,585	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)		660,861		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/25/2013 5:37 pm
		Title XVIII	Hospital	Cost
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		3,054,027	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)		3,054,027	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		3,084,567	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		28,683	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,975,438	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		1,080,446	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,080,446	30.00
31.00	Primary payer payments		345	31.00
32.00	Subtotal (line 30 minus line 31)		1,080,101	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		563,571	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		563,571	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		331,734	36.00
37.00	Subtotal (see instructions)		1,643,672	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00			0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,643,672	40.00
40.01	Sequestration adjustment (see instructions)		8,218	40.01
41.00	Interim payments		2,208,586	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-573,132	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
			Overrides	
			1.00	
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	override of Ancillary service charges (line 12)		0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151303

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/25/2013 5:37 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,193,576		2,208,586	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
<b>Program to Provider</b>							
3.01	ADJUSTMENTS TO PROVIDER	01/15/2013	37,000		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
<b>Provider to Program</b>							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		37,000		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)		1,230,576		2,208,586	4.00	
<b>TO BE COMPLETED BY CONTRACTOR</b>							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
<b>Program to Provider</b>							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
<b>Provider to Program</b>							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		111,967		564,914	6.02	
7.00	Total Medicare program liability (see instructions)		1,118,609		1,643,672	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: 151303  
Component CCN: 152303

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/25/2013 5:37 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		590,687		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
<b>Program to Provider</b>							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
<b>Provider to Program</b>							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		590,687		0		4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
<b>Program to Provider</b>							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
<b>Provider to Program</b>							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		22,048		0		6.02
7.00	Total Medicare program liability (see instructions)		568,639		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: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet E-2
		Component CCN: 152303		Date/Time Prepared: 11/25/2013 5:37 pm
Title XVIII		Swing Beds - SNF		Cost
		Part A	Part B	
		1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	477,568	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)	95,173	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	318	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)	572,741	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	572,741	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)	572,741	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,102	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)	568,639	0	15.00
16.00		0	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	568,639	0	19.00
19.01	Sequestration adjustment (see instructions)	2,843	0	19.01
20.00	Interim payments	590,687	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	-24,891	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: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part V Date/Time Prepared: 11/25/2013 5:37 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)</b>				
1.00	Inpatient services			1,280,065 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)			1,280,065 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,292,866 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,292,866 19.00
20.00	Deductibles (exclude professional component)			182,063 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			1,110,803 22.00
23.00	Coinsurance			1,734 23.00
24.00	Subtotal (line 22 minus line 23)			1,109,069 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			9,540 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			9,540 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			158 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,118,609 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)			1,118,609 30.00
30.01	Sequestration adjustment (see instructions)			5,593 30.01
31.00	Interim payments			1,230,576 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			-117,560 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

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

Provider CCN: 151303

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

Worksheet G

Date/Time Prepared:  
11/25/2013 5:37 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	1,419,048	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	6,532,309	0	0	0	4.00
5.00	Other receivable	4,434	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,825,306	0	0	0	6.00
7.00	Inventory	180,186	0	0	0	7.00
8.00	Prepaid expenses	131,485	0	0	0	8.00
9.00	Other current assets	11,714	0	0	0	9.00
10.00	Due from other funds	-177,410	177,410	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,276,460	177,410	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	127,944	0	0	0	12.00
13.00	Land improvements	409,779	0	0	0	13.00
14.00	Accumulated depreciation	-379,521	0	0	0	14.00
15.00	Buildings	13,643,807	0	0	0	15.00
16.00	Accumulated depreciation	-5,103,425	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	968,285	0	0	0	19.00
20.00	Accumulated depreciation	-854,730	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	3,300,235	0	0	0	23.00
24.00	Accumulated depreciation	-2,930,246	0	0	0	24.00
25.00	Minor equipment depreciable	36,626	0	0	0	25.00
26.00	Accumulated depreciation	-36,626	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)	9,182,128	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	6,345,266	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,345,266	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	19,803,854	177,410	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	2,759,129	0	0	0	37.00
38.00	Salaries, wages, and fees payable	666,954	0	0	0	38.00
39.00	Payroll taxes payable	77,553	0	0	0	39.00
40.00	Notes and loans payable (short term)	155,064	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	696,357	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,355,057	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,617,274	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	749,364	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,366,638	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,721,695	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	4,082,159	0	0	0	52.00
53.00	Specific purpose fund	0	177,410	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	4,082,159	177,410	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	19,803,854	177,410	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151303

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

Worksheet G-1

Date/Time Prepared:  
11/25/2013 5:37 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		2,672,614		203,517	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		1,331,868			2.00
3.00	Total (sum of line 1 and line 2)		4,004,482		203,517	3.00
4.00	RESTRICTED CONTR. USED FOR PROPERTY	42,999		20,484		4.00
5.00	DEFERRED PENSION COSTS	39,055		0		5.00
6.00	GRANT REVENUE	0		222,964		6.00
7.00	ROUNDING	3		1		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		82,057		243,449	10.00
11.00	Subtotal (line 3 plus line 10)		4,086,539		446,966	11.00
12.00	TRANSFERS TO AFFILIATES	4,380		0		12.00
13.00	TEMP RESTRICTED - RELEASED CAPITAL	0		42,999		13.00
14.00	TEMP RESTRICTED - RELEASED OPERATING	0		226,557		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)		4,380		269,556	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		4,082,159		177,410	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	RESTRICTED CONTR. USED FOR PROPERTY		0			4.00
5.00	DEFERRED PENSION COSTS		0			5.00
6.00	GRANT REVENUE		0			6.00
7.00	ROUNDING		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	TRANSFERS TO AFFILIATES		0			12.00
13.00	TEMP RESTRICTED - RELEASED CAPITAL		0			13.00
14.00	TEMP RESTRICTED - RELEASED OPERATING		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: 151303

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/25/2013 5:37 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital	1,965,581		1,965,581	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)	1,965,581		1,965,581	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
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)	1,965,581		1,965,581	17.00
18.00	Ancillary services	2,999,097	35,411,409	38,410,506	18.00
19.00	Outpatient services	568,360	13,396,542	13,964,902	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	699,512	699,512	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	5,533,038	49,507,463	55,040,501	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per wkst. A, column 3, line 200)		17,013,717		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	RHC DEPRECIATION - NONALLOWABLE	860			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)		860		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		17,012,857		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151303	Period: From 07/01/2012 To 06/30/2013	Worksheet G-3 Date/Time Prepared: 11/25/2013 5:37 pm
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		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	55,040,501	1.00
2.00	Less contractual allowances and discounts on patients' accounts	37,790,139	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,250,362	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	17,012,857	4.00
5.00	Net income from service to patients (line 3 minus line 4)	237,505	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	204,566	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	33,658	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	13,364	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	2,546	21.00
22.00	Rental of hospital space	341,428	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANTS	4,311	24.00
24.01	UNREALIZED GAINS / LOSSES	100,477	24.01
24.02	OTHER MISC INCOME	32,647	24.02
24.03	MEDICAID EHR INCENTIVES	223,295	24.03
24.04	GAIN ON SALE OF ASSET	1,000	24.04
24.05	OPER. NET ASSETS RELEASED FROM RESTR	226,557	24.05
24.06		0	24.06
25.00	Total other income (sum of lines 6-24)	1,183,849	25.00
26.00	Total (line 5 plus line 25)	1,421,354	26.00
27.00	RESTRUCTURING & OTHER NON-RECURRING EX	89,482	27.00
27.01	ROUNDING	4	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	89,486	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,331,868	29.00

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

Provider Name: ST. VINCENT JENNINGS HOSPITAL

Health Financial Systems

Provider No: 151303

MCRIF32

**Allocation of Physician Compensation: Hours**

**Department:** MEDICAL AFFAIRS

**Physician:** AGGREGATE MEDICAL / SURGERY PHYSICIANS

**Provider:** ST. VINCENT JENNINGS HOSPITAL

**Number:** 151303

**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.	2080.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	2080.00
5. Professional Component Percentage (Line 2 / Line 4)	100.00 %
6. Provider Component Percentage - (Line 1D / Line 4)	0.00 %

\_\_\_\_\_  
Signature: Physician or Physician Department Head

\_\_\_\_\_  
Date

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CMS 339 Questionnaire - Exhibit 1  
 Date Prepared: 11/25/2013 5:39:34 PM  
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 Fiscal Year: 07/01/2012 To 06/30/2013  
 Provider Name: ST. VINCENT JENNINGS HOSPITAL  
 Provider No: 151303

Health Financial Systems  
 MCRIF32

<b>Allocation of Physician Compensation: Hours</b>	<b>Provider:</b>	ST. VINCENT JENNINGS HOSPITAL
<b>Department:</b> RADIOLOGY	<b>Number:</b>	151303
<b>Physician:</b> AGGREGATE RADIOLOGY	<b>Specialty:</b>	RADIOLOGY-GENERAL

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

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

\_\_\_\_\_  
 Signature: Physician or Physician Department Head

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 Date

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CMS 339 Questionnaire - Exhibit 1  
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 Fiscal Year: 07/01/2012 To 06/30/2013  
 Provider Name: ST. VINCENT JENNINGS HOSPITAL  
 Provider No: 151303

Health Financial Systems  
 MCRIF32

<b>Allocation of Physician Compensation: Hours</b>	<b>Provider:</b>	ST. VINCENT JENNINGS HOSPITAL
<b>Department:</b> LABORATORY	<b>Number:</b>	151303
<b>Physician:</b> AGGREGATE LABORATORY	<b>Specialty:</b>	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.	2080.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	2080.00
5. Professional Component Percentage (Line 2 / Line 4)	100.00 %
6. Provider Component Percentage - (Line 1D / Line 4)	0.00 %

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 Signature: Physician or Physician Department Head

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 Date

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CMS 339 Questionnaire - Exhibit 1  
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 Fiscal Year: 07/01/2012 To 06/30/2013  
 Provider Name: ST. VINCENT JENNINGS HOSPITAL  
 Provider No: 151303

Health Financial Systems  
 MCRIF32

<b>Allocation of Physician Compensation: Hours</b>	<b>Provider:</b>	ST. VINCENT JENNINGS HOSPITAL
<b>Department:</b> EMERGENCY DEPARTMENT	<b>Number:</b>	151303
<b>Physician:</b> AGGREGATE EMERGENCY ROOM PHYSICIANS	<b>Specialty:</b>	EMERGENCY MEDICINE-GENERAL

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

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Health Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	4912.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	4912.00
2. Physician Services: Medical and Surgical Services to Individual Patients.	3848.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	8760.00
5. Professional Component Percentage (Line 2 / Line 4)	43.93 %
6. Provider Component Percentage - (Line 1D / Line 4)	56.07 %

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 Signature: Physician or Physician Department Head

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 Date

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