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: 151301	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/21/2014 9:48 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/21/2014 Time: 9:48 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 RANDOLPH HOSPITAL (151301) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 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.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-58,120	-563,075	0	1	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	-51,954	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-110,074	-563,075	0	1	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.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2014 8:34 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 473 GREENVILLE AVE.	PO Box:			1.00
2.00	City: WINCHESTER	State: IN	Zip Code: 47934	County: RANDOLPH	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. VINCENT RANDOLPH HOSPITAL	151301	34620	1	01/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT RANDOLPH SWING BEDS	15Z301	34620		09/01/1999	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2013	06/30/2014	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2014 8:34 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)			39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			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	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2014 8:34 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2014 8:34 am

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00

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		V	XIX	
		1.00	2.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	14,753	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 high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

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		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 10330 N. MERIDIAN ST. SUITE 420	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00

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

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

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

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	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	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: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2014 8:34 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	10/20/2014	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: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/21/2014 8:34 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3232	JILL.HILL@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/21/2014 8:34 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	10/20/2014			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 11/21/2014 8:34 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	42,024.00	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	42,024.00	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	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	42,024.00	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2014 8:34 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	752	52	1,751			1.00
2.00	HMO and other (see instructions)	131	349				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	193	0	193			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	55			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	945	52	1,999			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		311	420			13.00
14.00	Total (see instructions)	945	363	2,419	0.00	137.74	14.00
15.00	CAH visits	12,641	2,771	40,742			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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	137.74	27.00
28.00	Observation Bed Days		0	558			28.00
29.00	Ambulance Trips	3					29.00
30.00	Employee discount days (see instruction)			30			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	57	93			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2014 8:34 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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	265	42	747	1.00
2.00	HMO and other (see instructions)			40	0		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	265	42	747	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-10 | Date/Time Prepared: 11/21/2014 8:34 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.261708	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,783,637	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,752,374	5.00
6.00	Medicaid charges	16,654,623	6.00
7.00	Medicaid cost (line 1 times line 6)	4,358,648	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)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	97,748	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	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	6,668,762	47,010	6,715,772	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,745,268	12,303	1,757,571	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,745,268	12,303	1,757,571	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,750,706	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	491,835	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,258,871	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	591,165	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,348,736	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,348,736	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/21/2014 8:34 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,087,190	1,087,190	0	1,087,190	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		269,645	269,645	0	269,645	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	125,708	2,323,452	2,449,160	0	2,449,160	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,609,089	2,999,978	4,609,067	-2,911	4,606,156	5.00
7.00	00700	OPERATION OF PLANT	257,570	1,077,153	1,334,723	-1,618	1,333,105	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	49,279	49,279	0	49,279	8.00
9.00	00900	HOUSEKEEPING	0	320,035	320,035	0	320,035	9.00
10.00	01000	DIETARY	0	398,609	398,609	-251,463	147,146	10.00
11.00	01100	CAFETERIA	0	0	0	251,463	251,463	11.00
13.00	01300	NURSING ADMINISTRATION	621,093	55,848	676,941	-46	676,895	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	101,876	25,405	127,281	-40	127,241	14.00
15.00	01500	PHARMACY	262,062	663,953	926,015	-758	925,257	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	187,376	68,765	256,141	0	256,141	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,924,688	261,862	2,186,550	-692,553	1,493,997	30.00
43.00	04300	NURSERY	0	0	0	208,059	208,059	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	388,258	665,313	1,053,571	-102,248	951,323	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	448,454	448,454	52.00
53.00	05300	ANESTHESIOLOGY	221,405	54,740	276,145	0	276,145	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	565,117	105,952	671,069	-1,887	669,182	54.00
57.00	05700	CT SCAN	46,448	32,675	79,123	-783	78,340	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	44,885	178,374	223,259	-13	223,246	58.00
60.00	06000	LABORATORY	0	1,402,154	1,402,154	-133	1,402,021	60.00
65.00	06500	RESPIRATORY THERAPY	384,310	34,217	418,527	-104,267	314,260	65.00
65.01	03950	SLEEP LAB	51,562	30,723	82,285	-1,623	80,662	65.01
66.00	06600	PHYSICAL THERAPY	304,785	30,865	335,650	-2,277	333,373	66.00
67.00	06700	OCCUPATIONAL THERAPY	56,918	49	56,967	0	56,967	67.00
69.00	06900	ELECTROCARDIOLOGY	13,558	26,181	39,739	93,993	133,732	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,200	3,200	0	3,200	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	80,208	80,208	208,981	289,189	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	183,244	183,244	0	183,244	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	218,478	116,411	334,889	-9,644	325,245	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	755,677	1,121,559	1,877,236	-38,173	1,839,063	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,140,863	13,667,039	21,807,902	513	21,808,415	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	37,899	3,705	41,604	-224	41,380	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	31,440	78,155	109,595	-7	109,588	194.01
194.02	07952	OTHER NRCC - GRANTS	13,329	89,456	102,785	-282	102,503	194.02
200.00		TOTAL (SUM OF LINES 118-199)	8,223,531	13,838,355	22,061,886	0	22,061,886	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/21/2014 8:34 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-567,717	519,473		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,265	270,910		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	18,544	2,467,704		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	682,234	5,288,390		5.00
7.00	00700	OPERATION OF PLANT	-18,018	1,315,087		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	49,279		8.00
9.00	00900	HOUSEKEEPING	0	320,035		9.00
10.00	01000	DIETARY	0	147,146		10.00
11.00	01100	CAFETERIA	-73,077	178,386		11.00
13.00	01300	NURSING ADMINISTRATION	-33	676,862		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	127,241		14.00
15.00	01500	PHARMACY	-783	924,474		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,108	250,033		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-590,401	903,596		30.00
43.00	04300	NURSERY	0	208,059		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-237,500	713,823		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	448,454		52.00
53.00	05300	ANESTHESIOLOGY	-267,933	8,212		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-7,416	661,766		54.00
57.00	05700	CT SCAN	0	78,340		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	223,246		58.00
60.00	06000	LABORATORY	0	1,402,021		60.00
65.00	06500	RESPIRATORY THERAPY	0	314,260		65.00
65.01	03950	SLEEP LAB	0	80,662		65.01
66.00	06600	PHYSICAL THERAPY	-6,270	327,103		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	56,967		67.00
69.00	06900	ELECTROCARDIOLOGY	0	133,732		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,200		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	289,189		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	183,244		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	325,245		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-253,003	1,586,060		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,326,216	20,482,199		118.00
		NONREIMBURSABLE COST CENTERS				
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	41,380		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	137,200	137,200		194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	109,588		194.01
194.02	07952	OTHER NRCC - GRANTS	0	102,503		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-1,189,016	20,872,870		200.00

RECLASSIFICATIONS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/21/2014 8:34 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	0	251,463	1.00
	TOTALS		0	251,463	
	B - EKG				
1.00	ELECTROCARDIOLOGY	69.00	86,309	7,684	1.00
	TOTALS		86,309	7,684	
	C - NURSERY RECLASS				
1.00	NURSERY	43.00	181,101	26,958	1.00
	TOTALS		181,101	26,958	
	D - LDR RECLASS				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	390,348	58,106	1.00
	TOTALS		390,348	58,106	
	E - MEDICAL SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	208,981	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	TOTALS		0	208,981	
500.00	Grand Total: Increases		657,758	553,192	500.00

RECLASSIFICATIONS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/21/2014 8:34 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	0	251,463	0		1.00
	TOTALS		0	251,463			
	B - EKG						
1.00	RESPIRATORY THERAPY	65.00	86,309	7,684	0		1.00
	TOTALS		86,309	7,684			
	C - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	181,101	26,958	0		1.00
	TOTALS		181,101	26,958			
	D - LDR RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	390,348	58,106	0		1.00
	TOTALS		390,348	58,106			
	E - MEDICAL SUPPLIES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,911	0		1.00
2.00	OPERATION OF PLANT	7.00	0	1,618	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	46	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	40	0		4.00
5.00	PHARMACY	15.00	0	758	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	36,040	0		6.00
7.00	OPERATING ROOM	50.00	0	102,248	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,887	0		8.00
9.00	CT SCAN	57.00	0	783	0		9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	13	0		10.00
11.00	LABORATORY	60.00	0	133	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	10,274	0		12.00
13.00	SLEEP LAB	65.01	0	1,623	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	2,277	0		14.00
15.00	DRUGS CHARGED TO PATIENTS	73.00	0	9,644	0		15.00
16.00	EMERGENCY	91.00	0	38,173	0		16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	224	0		17.00
18.00	OTHER NRCC - FOUNDATION	194.01	0	7	0		18.00
19.00	OTHER NRCC - GRANTS	194.02	0	282	0		19.00
	TOTALS		0	208,981			
500.00	Grand Total: Decreases		657,758	553,192			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 11/21/2014 8:34 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	696,652	0	0	0	0	1.00
2.00	Land Improvements	25,100	0	0	0	0	2.00
3.00	Buildings and Fixtures	18,048,925	0	0	0	6,822	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	481,378	111,170	0	111,170	0	5.00
6.00	Movable Equipment	5,530,406	0	0	0	67,131	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,782,461	111,170	0	111,170	73,953	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,782,461	111,170	0	111,170	73,953	10.00

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	696,652	0				1.00
2.00	Land Improvements	25,100	0				2.00
3.00	Buildings and Fixtures	18,042,103	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	592,548	0				5.00
6.00	Movable Equipment	5,463,275	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	24,819,678	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	24,819,678	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 11/21/2014 8:34 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,087,190	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	269,645	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,356,835	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,087,190	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	269,645	2.00
3.00	Total (sum of lines 1-2)	0	1,356,835	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 11/21/2014 8:34 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	19,356,403	0	19,356,403	0.779881	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,463,275	0	5,463,275	0.220119	0	2.00
3.00	Total (sum of lines 1-2)	24,819,678	0	24,819,678	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	519,473	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	270,910	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	790,383	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	519,473	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	270,910	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	790,383	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/21/2014 8:34 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-251,048	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	A	-27,686	CAP REL COSTS-BLDG & FIXT	1.00	9	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,297,883			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	1,762,247			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-73,077	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PROVIDER ASSESSMENT TAX ADJUSTMENT	A	-1,107,888	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/21/2014 8:34 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	OTHER OPERATING INCOME	B	667	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	OTHER PLANT OPERATION REVENUE	B	-15,032	OPERATION OF PLANT	7.00	0	33.03
33.04	OTHER PHARMACY REVENUE	B	-783	PHARMACY	15.00	0	33.04
33.05	OTHER HIM REVENUE	B	-6,108	MEDICAL RECORDS & LIBRARY	16.00	0	33.05
33.06	OTHER OPERATING REVENUE	B	-887	ADULTS & PEDIATRICS	30.00	0	33.06
33.08	OTHER RADIOLOGY REVENUE	B	-1,565	RADIOLOGY-DIAGNOSTIC	54.00	0	33.08
33.09	OTHER PHYSICAL THERAPY REVENUE	B	-5,570	PHYSICAL THERAPY	66.00	0	33.09
33.10	DONATIONS	A	-1,075	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	AHA & IHA DUES	A	-767	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.13	PAVILION DEPRECIATION	A	-2,507	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
33.14	CARRYFORWARD	A	-104,668	CAP REL COSTS-BLDG & FIXT	1.00	9	33.14
33.16	LOSS ON SALE OF PPE	A	1,265	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.16
33.17	HOSPITALIST	A	-56,618	ADULTS & PEDIATRICS	30.00	0	33.17
33.18	NON REIMB EXPENSE	A	-33	NURSING ADMINISTRATION	13.00	0	33.18
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,189,016				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-1 | Date/Time Prepared: 11/21/2014 8:34 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	0	91,898	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,895,469	1,104,172	2.00
3.00	194.00	OTHER NRCC - PUBLIC RELATION	HOME OFFICE	137,200	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ST. VINCENT HLTH CHARGEBACK	202,478	202,478	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HLTH CHARGEBACK	1,005,032	1,005,032	4.01
4.02	9.00	HOUSEKEEPING	ST. VINCENT HLTH CHARGEBACK	-62,868	-62,868	4.02
4.03	14.00	CENTRAL SERVICES & SUPPLY	ST. VINCENT HLTH CHARGEBACK	91,162	91,162	4.03
4.04	15.00	PHARMACY	ST. VINCENT HLTH CHARGEBACK	-174,120	-174,120	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HLTH CHARGEBACK	156,012	156,012	4.05
4.06	30.00	ADULTS & PEDIATRICS	ST. VINCENT HLTH CHARGEBACK	5,964	5,964	4.06
4.07	50.00	OPERATING ROOM	ST. VINCENT HLTH CHARGEBACK	3,852	3,852	4.07
4.08	53.00	ANESTHESIOLOGY	ST. VINCENT HLTH CHARGEBACK	6,468	6,468	4.08
4.09	54.00	RADIOLOGY-DIAGNOSTIC	ST. VINCENT HLTH CHARGEBACK	8,604	8,604	4.09
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	1,029,034	1,146,222	4.10
4.11	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	251,048	414,797	4.11
4.12	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	27,686	45,745	4.12
4.13	7.00	OPERATION OF PLANT	TRIMEDX	459,992	462,978	4.13
4.14	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	331,344	103,714	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	0.00			0	0	4.18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
5.00	0		0	6,374,357	4,612,110	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	G	ST. VINCENT HTH	100.00	ST. VINCENT HTH	100.00	6.00
7.00	G	ASCENSION	100.00	ASCENSION	100.00	7.00
8.00	B	ST. VINCENT HSP	100.00	ST. VINCENT HSP	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: 151301	Period: From 07/01/2013 To 06/30/2014	Worksheet A-8-1 Date/Time Prepared: 11/21/2014 8:34 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-91,898	0		1.00
2.00	1,791,297	0		2.00
3.00	137,200	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	0	0		4.09
4.10	-117,188	0		4.10
4.11	-163,749	9		4.11
4.12	-18,059	9		4.12
4.13	-2,986	0		4.13
4.14	227,630	0		4.14
4.15	0	0		4.15
4.16	0	0		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
5.00	1,762,247			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	ADMINISTRATION		6.00
7.00	ADMINISTRATION		7.00
8.00	HOSPITAL		8.00
9.00	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: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 11/21/2014 8:34 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	545,409	532,896	12,513	0	0	1.00
2.00	50.00	OPERATING ROOM	237,500	237,500	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	270,668	267,933	2,735	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	5,851	5,851	0	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	700	700	0	0	0	5.00
6.00	91.00	EMERGENCY	955,319	253,003	702,316	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,015,447	1,297,883	717,564		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	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	532,896		1.00
2.00	50.00	OPERATING ROOM	0	0	0	237,500		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	267,933		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	5,851		4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	700		5.00
6.00	91.00	EMERGENCY	0	0	0	253,003		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,297,883		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/21/2014 8:34 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	519,473	519,473				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	270,910		270,910			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,467,704	0	0	2,467,704		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,288,390	81,723	42,620	537,598	5,950,331	5.00
7.00	00700	OPERATION OF PLANT	1,315,087	31,039	16,187	86,054	1,448,367	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	49,279	4,237	2,210	0	55,726	8.00
9.00	00900	HOUSEKEEPING	320,035	3,973	2,072	0	326,080	9.00
10.00	01000	DIETARY	147,146	14,738	7,686	0	169,570	10.00
11.00	01100	CAFETERIA	178,386	3,469	1,809	0	183,664	11.00
13.00	01300	NURSING ADMINISTRATION	676,862	953	497	207,508	885,820	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	127,241	0	0	34,037	161,278	14.00
15.00	01500	PHARMACY	924,474	0	0	87,991	1,012,465	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	250,033	9,819	5,121	62,603	327,576	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	903,596	60,490	31,546	287,792	1,283,424	30.00
43.00	04300	NURSERY	208,059	828	432	60,506	269,825	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	713,823	51,147	26,674	129,717	921,361	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	448,454	15,553	8,111	130,416	602,534	52.00
53.00	05300	ANESTHESIOLOGY	8,212	0	0	747	8,959	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	661,766	41,203	21,488	188,806	913,263	54.00
57.00	05700	CT SCAN	78,340	0	0	15,518	93,858	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	223,246	0	0	14,996	238,242	58.00
60.00	06000	LABORATORY	1,402,021	11,540	6,018	0	1,419,579	60.00
65.00	06500	RESPIRATORY THERAPY	314,260	12,044	6,281	99,562	432,147	65.00
65.01	03950	SLEEP LAB	80,662	2,807	1,464	17,227	102,160	65.01
66.00	06600	PHYSICAL THERAPY	327,103	19,896	10,376	101,595	458,970	66.00
67.00	06700	OCCUPATIONAL THERAPY	56,967	2,099	1,095	19,016	79,177	67.00
69.00	06900	ELECTROCARDIOLOGY	133,732	0	0	33,366	167,098	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,200	0	0	0	3,200	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	289,189	11,143	5,811	0	306,143	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	183,244	0	0	0	183,244	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	325,245	7,661	3,995	72,558	409,459	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,586,060	28,133	14,671	252,472	1,881,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,482,199	414,495	216,164	2,440,085	20,294,856	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	847	442	0	1,289	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	41,380	103,257	53,848	12,662	211,147	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	137,200	437	228	0	137,865	194.00
194.01	07951	OTHER NRCC - FOUNDATION	109,588	437	228	10,504	120,757	194.01
194.02	07952	OTHER NRCC - GRANTS	102,503	0	0	4,453	106,956	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	20,872,870	519,473	270,910	2,467,704	20,872,870	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/21/2014 8:34 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,950,331					5.00
7.00	00700	OPERATION OF PLANT	577,533	2,025,900				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,221	21,108	99,055			8.00
9.00	00900	HOUSEKEEPING	130,024	19,788	0	475,892		9.00
10.00	01000	DIETARY	67,616	73,415	0	17,601	328,202	10.00
11.00	01100	CAFETERIA	73,236	17,282	0	4,143	0	11.00
13.00	01300	NURSING ADMINISTRATION	353,219	4,749	0	1,139	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	64,309	0	0	0	0	14.00
15.00	01500	PHARMACY	403,718	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130,620	48,910	0	11,726	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	511,763	301,311	38,253	72,237	328,202	30.00
43.00	04300	NURSERY	107,592	4,123	0	988	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	367,391	254,775	11,054	61,081	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	240,259	77,471	0	18,573	0	52.00
53.00	05300	ANESTHESIOLOGY	3,572	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	364,162	205,238	11,057	49,205	0	54.00
57.00	05700	CT SCAN	37,426	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	94,999	0	0	0	0	58.00
60.00	06000	LABORATORY	566,054	57,485	0	13,782	0	60.00
65.00	06500	RESPIRATORY THERAPY	172,318	59,992	0	14,383	0	65.00
65.01	03950	SLEEP LAB	40,736	13,984	0	3,353	0	65.01
66.00	06600	PHYSICAL THERAPY	183,013	99,107	0	23,760	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,572	10,455	0	2,506	0	67.00
69.00	06900	ELECTROCARDIOLOGY	66,630	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,276	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	122,074	55,506	0	13,307	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,068	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	163,271	38,159	0	9,148	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	750,178	140,135	38,691	33,596	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,719,850	1,502,993	99,055	350,528	328,202	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	514	4,222	0	1,012	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	84,194	514,331	0	123,308	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	54,973	2,177	0	522	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	48,152	2,177	0	522	0	194.01
194.02	07952	OTHER NRCC - GRANTS	42,648	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,950,331	2,025,900	99,055	475,892	328,202	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/21/2014 8:34 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	278,325					11.00
13.00	01300	NURSING ADMINISTRATION	28,772	1,273,699				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,435	0	232,022			14.00
15.00	01500	PHARMACY	7,618	0	0	1,423,801		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,888	0	0	0	534,720	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,020	479,556	0	0	29,604	30.00
43.00	04300	NURSERY	7,379	69,361	0	0	5,096	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,011	159,887	0	0	60,922	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,904	149,487	0	0	10,984	52.00
53.00	05300	ANESTHESIOLOGY	17	156	0	0	4,659	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,096	0	0	0	55,597	54.00
57.00	05700	CT SCAN	2,311	0	0	0	84,144	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,918	0	0	0	18,654	58.00
60.00	06000	LABORATORY	0	0	0	0	117,981	60.00
65.00	06500	RESPIRATORY THERAPY	15,076	0	0	0	13,999	65.00
65.01	03950	SLEEP LAB	2,255	0	0	0	3,578	65.01
66.00	06600	PHYSICAL THERAPY	15,110	0	0	0	12,616	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,149	0	0	0	3,085	67.00
69.00	06900	ELECTROCARDIOLOGY	4,884	0	0	0	6,634	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	134	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	117,251	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	114,771	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,296	0	0	1,423,801	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	41,053	385,863	0	0	107,033	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	270,192	1,244,310	232,022	1,423,801	534,720	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,127	29,389	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	1,746	0	0	0	0	194.01
194.02	07952	OTHER NRCC - GRANTS	3,260	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	278,325	1,273,699	232,022	1,423,801	534,720	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/21/2014 8:34 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,095,370	0	3,095,370		30.00
43.00	04300	NURSERY	464,364	0	464,364		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,853,482	0	1,853,482		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,115,212	0	1,115,212		52.00
53.00	05300	ANESTHESIOLOGY	17,363	0	17,363		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,624,618	0	1,624,618		54.00
57.00	05700	CT SCAN	217,739	0	217,739		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	353,813	0	353,813		58.00
60.00	06000	LABORATORY	2,174,881	0	2,174,881		60.00
65.00	06500	RESPIRATORY THERAPY	707,915	0	707,915		65.00
65.01	03950	SLEEP LAB	166,066	0	166,066		65.01
66.00	06600	PHYSICAL THERAPY	792,576	0	792,576		66.00
67.00	06700	OCCUPATIONAL THERAPY	128,944	0	128,944		67.00
69.00	06900	ELECTROCARDIOLOGY	245,246	0	245,246		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,610	0	4,610		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	614,281	0	614,281		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	371,083	0	371,083		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,053,134	0	2,053,134		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,377,885	0	3,377,885		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,378,582	0	19,378,582		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,037	0	7,037		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	965,496	0	965,496		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	195,537	0	195,537		194.00
194.01	07951	OTHER NRCC - FOUNDATION	173,354	0	173,354		194.01
194.02	07952	OTHER NRCC - GRANTS	152,864	0	152,864		194.02
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)	20,872,870	0	20,872,870		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 11/21/2014 8:34 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	377,143	81,723	42,620	501,486	0	5.00
7.00	00700	OPERATION OF PLANT	0	31,039	16,187	47,226	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,237	2,210	6,447	0	8.00
9.00	00900	HOUSEKEEPING	0	3,973	2,072	6,045	0	9.00
10.00	01000	DIETARY	0	14,738	7,686	22,424	0	10.00
11.00	01100	CAFETERIA	0	3,469	1,809	5,278	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	953	497	1,450	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	34,644	0	0	34,644	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,753	9,819	5,121	17,693	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61,491	60,490	31,546	153,527	0	30.00
43.00	04300	NURSERY	0	828	432	1,260	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,855	51,147	26,674	121,676	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	15,553	8,111	23,664	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	41,203	21,488	62,691	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	177,400	0	0	177,400	0	58.00
60.00	06000	LABORATORY	375	11,540	6,018	17,933	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,726	12,044	6,281	20,051	0	65.00
65.01	03950	SLEEP LAB	458	2,807	1,464	4,729	0	65.01
66.00	06600	PHYSICAL THERAPY	4,421	19,896	10,376	34,693	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,099	1,095	3,194	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,143	5,811	16,954	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,661	3,995	11,656	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,742	28,133	14,671	46,546	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	708,008	414,495	216,164	1,338,667	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	847	442	1,289	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	481	103,257	53,848	157,586	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	437	228	665	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	437	228	665	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	708,489	519,473	270,910	1,498,872	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 11/21/2014 8:34 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	501,486					5.00
7.00	00700	OPERATION OF PLANT	48,674	95,900				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,873	999	9,319			8.00
9.00	00900	HOUSEKEEPING	10,958	937	0	17,940		9.00
10.00	01000	DIETARY	5,699	3,475	0	664	32,262	10.00
11.00	01100	CAFETERIA	6,172	818	0	156	0	11.00
13.00	01300	NURSING ADMINISTRATION	29,769	225	0	43	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,420	0	0	0	0	14.00
15.00	01500	PHARMACY	34,025	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,009	2,315	0	442	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,131	14,263	3,599	2,723	32,262	30.00
43.00	04300	NURSERY	9,068	195	0	37	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,963	12,060	1,040	2,303	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,249	3,667	0	700	0	52.00
53.00	05300	ANESTHESIOLOGY	301	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,691	9,715	1,040	1,855	0	54.00
57.00	05700	CT SCAN	3,154	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,006	0	0	0	0	58.00
60.00	06000	LABORATORY	47,706	2,721	0	520	0	60.00
65.00	06500	RESPIRATORY THERAPY	14,523	2,840	0	542	0	65.00
65.01	03950	SLEEP LAB	3,433	662	0	126	0	65.01
66.00	06600	PHYSICAL THERAPY	15,424	4,691	0	896	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,661	495	0	94	0	67.00
69.00	06900	ELECTROCARDIOLOGY	5,615	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	108	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,288	2,628	0	502	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,158	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,760	1,806	0	345	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	63,224	6,634	3,640	1,267	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	482,062	71,146	9,319	13,215	32,262	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43	200	0	38	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,096	24,348	0	4,647	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	4,633	103	0	20	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	4,058	103	0	20	0	194.01
194.02	07952	OTHER NRCC - GRANTS	3,594	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	501,486	95,900	9,319	17,940	32,262	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/21/2014 8:34 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	12,424					11.00
13.00	01300	NURSING ADMINISTRATION	1,284	32,771				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	287	0	5,707			14.00
15.00	01500	PHARMACY	340	0	0	69,009		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	709	0	0	0	32,168	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,277	12,338	0	0	1,780	30.00
43.00	04300	NURSERY	329	1,785	0	0	306	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	759	4,114	0	0	3,663	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	710	3,846	0	0	660	52.00
53.00	05300	ANESTHESIOLOGY	1	4	0	0	280	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,165	0	0	0	3,343	54.00
57.00	05700	CT SCAN	103	0	0	0	5,059	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	86	0	0	0	1,122	58.00
60.00	06000	LABORATORY	0	0	0	0	7,111	60.00
65.00	06500	RESPIRATORY THERAPY	673	0	0	0	842	65.00
65.01	03950	SLEEP LAB	101	0	0	0	215	65.01
66.00	06600	PHYSICAL THERAPY	674	0	0	0	759	66.00
67.00	06700	OCCUPATIONAL THERAPY	96	0	0	0	185	67.00
69.00	06900	ELECTROCARDIOLOGY	218	0	0	0	399	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	8	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,884	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,823	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	415	0	0	69,009	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,833	9,928	0	0	6,436	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,060	32,015	5,707	69,009	32,168	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	140	756	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	78	0	0	0	0	194.01
194.02	07952	OTHER NRCC - GRANTS	146	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,424	32,771	5,707	69,009	32,168	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 11/21/2014 8:34 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	265,900	0	265,900		30.00
43.00	04300	NURSERY	12,980	0	12,980		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	176,578	0	176,578		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,496	0	53,496		52.00
53.00	05300	ANESTHESIOLOGY	586	0	586		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,500	0	110,500		54.00
57.00	05700	CT SCAN	8,316	0	8,316		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	186,614	0	186,614		58.00
60.00	06000	LABORATORY	75,991	0	75,991		60.00
65.00	06500	RESPIRATORY THERAPY	39,471	0	39,471		65.00
65.01	03950	SLEEP LAB	9,266	0	9,266		65.01
66.00	06600	PHYSICAL THERAPY	57,137	0	57,137		66.00
67.00	06700	OCCUPATIONAL THERAPY	6,725	0	6,725		67.00
69.00	06900	ELECTROCARDIOLOGY	6,232	0	6,232		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	116	0	116		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,256	0	33,256		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,981	0	8,981		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	96,991	0	96,991		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	139,508	0	139,508		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,288,644	0	1,288,644		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,570	0	1,570		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	194,573	0	194,573		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	5,421	0	5,421		194.00
194.01	07951	OTHER NRCC - FOUNDATION	4,924	0	4,924		194.01
194.02	07952	OTHER NRCC - GRANTS	3,740	0	3,740		194.02
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)	1,498,872	0	1,498,872		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/21/2014 8:34 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	78,458					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		78,458				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,386,106			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,343	12,343	1,609,089	-5,950,331	14,922,539	5.00
7.00	00700	OPERATION OF PLANT	4,688	4,688	257,570	0	1,448,367	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	640	640	0	0	55,726	8.00
9.00	00900	HOUSEKEEPING	600	600	0	0	326,080	9.00
10.00	01000	DIETARY	2,226	2,226	0	0	169,570	10.00
11.00	01100	CAFETERIA	524	524	0	0	183,664	11.00
13.00	01300	NURSING ADMINISTRATION	144	144	621,093	0	885,820	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	101,876	0	161,278	14.00
15.00	01500	PHARMACY	0	0	263,366	0	1,012,465	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,483	1,483	187,376	0	327,576	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,136	9,136	861,392	0	1,283,424	30.00
43.00	04300	NURSERY	125	125	181,101	0	269,825	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,725	7,725	388,258	0	921,361	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,349	2,349	390,348	0	602,534	52.00
53.00	05300	ANESTHESIOLOGY	0	0	2,236	0	8,959	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,223	6,223	565,117	0	913,263	54.00
57.00	05700	CT SCAN	0	0	46,448	0	93,858	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	44,885	0	238,242	58.00
60.00	06000	LABORATORY	1,743	1,743	0	0	1,419,579	60.00
65.00	06500	RESPIRATORY THERAPY	1,819	1,819	298,001	0	432,147	65.00
65.01	03950	SLEEP LAB	424	424	51,562	0	102,160	65.01
66.00	06600	PHYSICAL THERAPY	3,005	3,005	304,085	0	458,970	66.00
67.00	06700	OCCUPATIONAL THERAPY	317	317	56,918	0	79,177	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	99,867	0	167,098	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	3,200	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,683	1,683	0	0	306,143	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	183,244	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,157	1,157	217,173	0	409,459	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,249	4,249	755,677	0	1,881,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,603	62,603	7,303,438	-5,950,331	14,344,525	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	128	128	0	0	1,289	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,595	15,595	37,899	0	211,147	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	66	66	0	0	137,865	194.00
194.01	07951	OTHER NRCC - FOUNDATION	66	66	31,440	0	120,757	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	13,329	0	106,956	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	519,473	270,910	2,467,704		5,950,331	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.621033	3.452930	0.334101		0.398748	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		501,486	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.033606	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/21/2014 8:34 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	61,427					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	640	105,479				8.00
9.00	00900	HOUSEKEEPING	600	0	60,187			9.00
10.00	01000	DIETARY	2,226	0	2,226	100		10.00
11.00	01100	CAFETERIA	524	0	524	0	200,725	11.00
13.00	01300	NURSING ADMINISTRATION	144	0	144	0	20,750	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	4,641	14.00
15.00	01500	PHARMACY	0	0	0	0	5,494	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,483	0	1,483	0	11,458	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,136	40,734	9,136	100	36,796	30.00
43.00	04300	NURSERY	125	0	125	0	5,322	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,725	11,771	7,725	0	12,268	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,349	0	2,349	0	11,470	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	12	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,223	11,774	6,223	0	18,820	54.00
57.00	05700	CT SCAN	0	0	0	0	1,667	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	1,383	58.00
60.00	06000	LABORATORY	1,743	0	1,743	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,819	0	1,819	0	10,873	65.00
65.01	03950	SLEEP LAB	424	0	424	0	1,626	65.01
66.00	06600	PHYSICAL THERAPY	3,005	0	3,005	0	10,897	66.00
67.00	06700	OCCUPATIONAL THERAPY	317	0	317	0	1,550	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	3,522	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,683	0	1,683	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,157	0	1,157	0	6,704	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,249	41,200	4,249	0	29,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,572	105,479	44,332	100	194,860	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	128	0	128	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,595	0	15,595	0	2,255	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	66	0	66	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	66	0	66	0	1,259	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	2,351	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,025,900	99,055	475,892	328,202	278,325	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.980611	0.939097	7.906890	3,282.020000	1.386599	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	95,900	9,319	17,940	32,262	12,424	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.561203	0.088349	0.298071	322.620000	0.061896	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/21/2014 8:34 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	97,730					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	472,433				14.00
15.00	01500	PHARMACY	0	0	10,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	65,078,819		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,796	0	0	3,603,182		30.00
43.00	04300	NURSERY	5,322	0	0	620,235		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,268	0	0	7,415,049		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,470	0	0	1,336,861		52.00
53.00	05300	ANESTHESIOLOGY	12	0	0	567,059		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,766,945		54.00
57.00	05700	CT SCAN	0	0	0	10,241,426		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,270,446		58.00
60.00	06000	LABORATORY	0	0	0	14,355,989		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,703,891		65.00
65.01	03950	SLEEP LAB	0	0	0	435,523		65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	1,535,566		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	375,459		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	807,507		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	16,320		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	238,742	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	233,691	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	10,000	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	29,607	0	0	13,027,361		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	95,475	472,433	10,000	65,078,819		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,255	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0		194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	0	0	0		194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,273,699	232,022	1,423,801	534,720		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.032835	0.491121	142.380100	0.008216		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	32,771	5,707	69,009	32,168		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.335322	0.012080	6.900900	0.000494		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,095,370		3,095,370	0	0	30.00
43.00	04300	NURSERY	464,364		464,364	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,853,482		1,853,482	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,115,212		1,115,212	0	0	52.00
53.00	05300	ANESTHESIOLOGY	17,363		17,363	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,624,618		1,624,618	0	0	54.00
57.00	05700	CT SCAN	217,739		217,739	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	353,813		353,813	0	0	58.00
60.00	06000	LABORATORY	2,174,881		2,174,881	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	707,915	0	707,915	0	0	65.00
65.01	03950	SLEEP LAB	166,066	0	166,066	0	0	65.01
66.00	06600	PHYSICAL THERAPY	792,576	0	792,576	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	128,944	0	128,944	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	245,246		245,246	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,610		4,610	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	614,281		614,281	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	371,083		371,083	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,053,134		2,053,134	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,377,885		3,377,885	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	688,784		688,784		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	20,067,366	0	20,067,366	0	0	200.00
201.00		Less Observation Beds	688,784		688,784		0	201.00
202.00		Total (see instructions)	19,378,582	0	19,378,582	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,896,170		2,896,170			30.00
43.00	04300	NURSERY	620,235		620,235			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,564,624	5,850,425	7,415,049	0.249962	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	971,898	364,963	1,336,861	0.834202	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	82,421	484,638	567,059	0.030619	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	197,747	6,569,198	6,766,945	0.240081	0.000000	54.00
57.00	05700	CT SCAN	127,488	10,113,938	10,241,426	0.021261	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	24,479	2,245,967	2,270,446	0.155834	0.000000	58.00
60.00	06000	LABORATORY	801,987	13,554,002	14,355,989	0.151496	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	728,948	974,943	1,703,891	0.415470	0.000000	65.00
65.01	03950	SLEEP LAB	0	435,523	435,523	0.381302	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	140,495	1,395,071	1,535,566	0.516146	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,306	342,153	375,459	0.343430	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	103,491	704,016	807,507	0.303708	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	870	15,450	16,320	0.282475	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	865,116	1,419,361	2,284,477	0.268893	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	331,335	254,739	586,074	0.633167	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,307,000	4,790,243	6,097,243	0.336732	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,900	13,018,461	13,027,361	0.259292	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,796	705,216	707,012	0.974218	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	10,808,306	63,238,307	74,046,613			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,808,306	63,238,307	74,046,613			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
65.01	03950	SLEEP LAB	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
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: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 8:34 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,095,370		3,095,370	0	3,095,370	30.00
43.00	04300	NURSERY	464,364		464,364	0	464,364	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,853,482		1,853,482	0	1,853,482	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,115,212		1,115,212	0	1,115,212	52.00
53.00	05300	ANESTHESIOLOGY	17,363		17,363	0	17,363	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,624,618		1,624,618	0	1,624,618	54.00
57.00	05700	CT SCAN	217,739		217,739	0	217,739	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	353,813		353,813	0	353,813	58.00
60.00	06000	LABORATORY	2,174,881		2,174,881	0	2,174,881	60.00
65.00	06500	RESPIRATORY THERAPY	707,915	0	707,915	0	707,915	65.00
65.01	03950	SLEEP LAB	166,066	0	166,066	0	166,066	65.01
66.00	06600	PHYSICAL THERAPY	792,576	0	792,576	0	792,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	128,944	0	128,944	0	128,944	67.00
69.00	06900	ELECTROCARDIOLOGY	245,246		245,246	0	245,246	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,610		4,610	0	4,610	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	614,281		614,281	0	614,281	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	371,083		371,083	0	371,083	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,053,134		2,053,134	0	2,053,134	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,377,885		3,377,885	0	3,377,885	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	688,784		688,784		688,784	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	20,067,366	0	20,067,366	0	20,067,366	200.00
201.00		Less Observation Beds	688,784		688,784		688,784	201.00
202.00		Total (see instructions)	19,378,582	0	19,378,582	0	19,378,582	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 8:34 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,896,170		2,896,170			30.00
43.00	04300	NURSERY	620,235		620,235			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,564,624	5,850,425	7,415,049	0.249962	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	971,898	364,963	1,336,861	0.834202	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	82,421	484,638	567,059	0.030619	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	197,747	6,569,198	6,766,945	0.240081	0.000000	54.00
57.00	05700	CT SCAN	127,488	10,113,938	10,241,426	0.021261	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	24,479	2,245,967	2,270,446	0.155834	0.000000	58.00
60.00	06000	LABORATORY	801,987	13,554,002	14,355,989	0.151496	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	728,948	974,943	1,703,891	0.415470	0.000000	65.00
65.01	03950	SLEEP LAB	0	435,523	435,523	0.381302	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	140,495	1,395,071	1,535,566	0.516146	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,306	342,153	375,459	0.343430	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	103,491	704,016	807,507	0.303708	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	870	15,450	16,320	0.282475	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	865,116	1,419,361	2,284,477	0.268893	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	331,335	254,739	586,074	0.633167	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,307,000	4,790,243	6,097,243	0.336732	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,900	13,018,461	13,027,361	0.259292	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,796	705,216	707,012	0.974218	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	10,808,306	63,238,307	74,046,613			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,808,306	63,238,307	74,046,613			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 8:34 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	03950	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
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: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part II Date/Time Prepared: 11/21/2014 8:34 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,853,482	176,578	1,676,904	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,115,212	53,496	1,061,716	0	0	52.00
53.00	05300	ANESTHESIOLOGY	17,363	586	16,777	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,624,618	110,500	1,514,118	0	0	54.00
57.00	05700	CT SCAN	217,739	8,316	209,423	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	353,813	186,614	167,199	0	0	58.00
60.00	06000	LABORATORY	2,174,881	75,991	2,098,890	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	707,915	39,471	668,444	0	0	65.00
65.01	03950	SLEEP LAB	166,066	9,266	156,800	0	0	65.01
66.00	06600	PHYSICAL THERAPY	792,576	57,137	735,439	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	128,944	6,725	122,219	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	245,246	6,232	239,014	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,610	116	4,494	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	614,281	33,256	581,025	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	371,083	8,981	362,102	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,053,134	96,991	1,956,143	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,377,885	139,508	3,238,377	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	688,784	64,258	624,526	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	16,507,632	1,074,022	15,433,610	0	0	200.00
201.00		Less Observation Beds	688,784	64,258	624,526	0	0	201.00
202.00		Total (line 200 minus line 201)	15,818,848	1,009,764	14,809,084	0	0	202.00

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

Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part II Date/Time Prepared: 11/21/2014 8:34 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,853,482	7,415,049	0.249962		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,115,212	1,336,861	0.834202		52.00
53.00	05300	ANESTHESIOLOGY	17,363	567,059	0.030619		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,624,618	6,766,945	0.240081		54.00
57.00	05700	CT SCAN	217,739	10,241,426	0.021261		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	353,813	2,270,446	0.155834		58.00
60.00	06000	LABORATORY	2,174,881	14,355,989	0.151496		60.00
65.00	06500	RESPIRATORY THERAPY	707,915	1,703,891	0.415470		65.00
65.01	03950	SLEEP LAB	166,066	435,523	0.381302		65.01
66.00	06600	PHYSICAL THERAPY	792,576	1,535,566	0.516146		66.00
67.00	06700	OCCUPATIONAL THERAPY	128,944	375,459	0.343430		67.00
69.00	06900	ELECTROCARDIOLOGY	245,246	807,507	0.303708		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,610	16,320	0.282475		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	614,281	2,284,477	0.268893		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	371,083	586,074	0.633167		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,053,134	6,097,243	0.336732		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,377,885	13,027,361	0.259292		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	688,784	707,012	0.974218		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	16,507,632	70,530,208			200.00
201.00		Less Observation Beds	688,784	0			201.00
202.00		Total (line 200 minus line 201)	15,818,848	70,530,208			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	176,578	7,415,049	0.023813	313,737	7,471	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,496	1,336,861	0.040016	9,364	375	52.00
53.00	05300	ANESTHESIOLOGY	586	567,059	0.001033	16,184	17	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,500	6,766,945	0.016329	39,260	641	54.00
57.00	05700	CT SCAN	8,316	10,241,426	0.000812	82,655	67	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	186,614	2,270,446	0.082193	6,945	571	58.00
60.00	06000	LABORATORY	75,991	14,355,989	0.005293	293,028	1,551	60.00
65.00	06500	RESPIRATORY THERAPY	39,471	1,703,891	0.023165	426,196	9,873	65.00
65.01	03950	SLEEP LAB	9,266	435,523	0.021276	0	0	65.01
66.00	06600	PHYSICAL THERAPY	57,137	1,535,566	0.037209	48,149	1,792	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,725	375,459	0.017911	14,044	252	67.00
69.00	06900	ELECTROCARDIOLOGY	6,232	807,507	0.007718	100,375	775	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	116	16,320	0.007108	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,256	2,284,477	0.014557	312,809	4,554	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,981	586,074	0.015324	78,830	1,208	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	96,991	6,097,243	0.015907	546,786	8,698	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	139,508	13,027,361	0.010709	8,645	93	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	64,258	707,012	0.090887	1,796	163	92.00
200.00		Total (lines 50-199)	1,074,022	70,530,208		2,298,803	38,101	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Hospital | Cost

		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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,415,049	0.000000	0.000000	313,737	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,336,861	0.000000	0.000000	9,364	52.00
53.00	05300	ANESTHESIOLOGY	0	567,059	0.000000	0.000000	16,184	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,766,945	0.000000	0.000000	39,260	54.00
57.00	05700	CT SCAN	0	10,241,426	0.000000	0.000000	82,655	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,270,446	0.000000	0.000000	6,945	58.00
60.00	06000	LABORATORY	0	14,355,989	0.000000	0.000000	293,028	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,703,891	0.000000	0.000000	426,196	65.00
65.01	03950	SLEEP LAB	0	435,523	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	1,535,566	0.000000	0.000000	48,149	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	375,459	0.000000	0.000000	14,044	67.00
69.00	06900	ELECTROCARDIOLOGY	0	807,507	0.000000	0.000000	100,375	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	16,320	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,284,477	0.000000	0.000000	312,809	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	586,074	0.000000	0.000000	78,830	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,097,243	0.000000	0.000000	546,786	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	13,027,361	0.000000	0.000000	8,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	707,012	0.000000	0.000000	1,796	92.00
200.00		Total (lines 50-199)	0	70,530,208			2,298,803	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
65.01	03950	SLEEP LAB	0	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.249962	0	1,488,574	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.834202	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.030619	0	134,650	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240081	0	1,572,544	0	0	54.00
57.00	05700	CT SCAN	0.021261	0	3,049,035	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.155834	0	652,458	0	0	58.00
60.00	06000	LABORATORY	0.151496	0	3,311,369	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.415470	0	237,628	0	0	65.00
65.01	03950	SLEEP LAB	0.381302	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.516146	0	512,996	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.343430	0	94,866	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.303708	0	579,916	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.282475	0	136,490	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.268893	0	609,439	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.633167	0	90,256	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336732	0	1,669,423	2,714	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.259292	0	3,446,038	3,795	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.974218	0	243,455	0	0	92.00
200.00		Subtotal (see instructions)		0	17,829,137	6,509	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	17,829,137	6,509	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	372,087	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	4,123	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	377,538	0		54.00
57.00	05700	CT SCAN	64,826	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	101,675	0		58.00
60.00	06000	LABORATORY	501,659	0		60.00
65.00	06500	RESPIRATORY THERAPY	98,727	0		65.00
65.01	03950	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	264,781	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	32,580	0		67.00
69.00	06900	ELECTROCARDIOLOGY	176,125	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38,555	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	163,874	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	57,147	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	562,148	914		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	893,530	984		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	237,178	0		92.00
200.00		Subtotal (see instructions)	3,946,553	1,898		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,946,553	1,898		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151301 | Component CCN: 15Z301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.249962	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.834202	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.030619	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240081	0	0	0	0	54.00
57.00	05700	CT SCAN	0.021261	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.155834	0	0	0	0	58.00
60.00	06000	LABORATORY	0.151496	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.415470	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0.381302	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.516146	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.343430	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.303708	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.282475	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.268893	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.633167	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336732	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.259292	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.974218	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		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: 151301 | Component CCN: 15Z301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V | Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	03950	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
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			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part I Date/Time Prepared: 11/21/2014 8:34 am

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	265,900	20,511	245,389	2,309	106.28	30.00
43.00	NURSERY	12,980		12,980	420	30.90	43.00
200.00	Total (lines 30-199)	278,880		258,369	2,729		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	52	5,527				30.00
43.00	NURSERY	311	9,610				43.00
200.00	Total (lines 30-199)	363	15,137				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/21/2014 8:34 am

Title XIX | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	176,578	7,415,049	0.023813	460,325	10,962	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,496	1,336,861	0.040016	0	0	52.00
53.00	05300	ANESTHESIOLOGY	586	567,059	0.001033	24,649	25	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,500	6,766,945	0.016329	32,121	525	54.00
57.00	05700	CT SCAN	8,316	10,241,426	0.000812	30,233	25	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	186,614	2,270,446	0.082193	5,507	453	58.00
60.00	06000	LABORATORY	75,991	14,355,989	0.005293	289,833	1,534	60.00
65.00	06500	RESPIRATORY THERAPY	39,471	1,703,891	0.023165	118,419	2,743	65.00
65.01	03950	SLEEP LAB	9,266	435,523	0.021276	0	0	65.01
66.00	06600	PHYSICAL THERAPY	57,137	1,535,566	0.037209	3,275	122	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,725	375,459	0.017911	1,004	18	67.00
69.00	06900	ELECTROCARDIOLOGY	6,232	807,507	0.007718	3,116	24	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	116	16,320	0.007108	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,256	2,284,477	0.014557	73,048	1,063	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,981	586,074	0.015324	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	96,991	6,097,243	0.015907	295,083	4,694	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	139,508	13,027,361	0.010709	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	64,258	707,012	0.090887	0	0	92.00
200.00		Total (lines 50-199)	1,074,022	70,530,208		1,336,613	22,188	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part III Date/Time Prepared: 11/21/2014 8:34 am

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,309	0.00	52	0		30.00
43.00	04300	NURSERY	420	0.00	311	0		43.00
200.00		Total (lines 30-199)	2,729		363	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/21/2014 8:34 am

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/21/2014 8:34 am

Title XIX | Hospital | Cost

		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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,415,049	0.000000	0.000000	460,325	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,336,861	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	567,059	0.000000	0.000000	24,649	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,766,945	0.000000	0.000000	32,121	54.00
57.00	05700	CT SCAN	0	10,241,426	0.000000	0.000000	30,233	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,270,446	0.000000	0.000000	5,507	58.00
60.00	06000	LABORATORY	0	14,355,989	0.000000	0.000000	289,833	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,703,891	0.000000	0.000000	118,419	65.00
65.01	03950	SLEEP LAB	0	435,523	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	1,535,566	0.000000	0.000000	3,275	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	375,459	0.000000	0.000000	1,004	67.00
69.00	06900	ELECTROCARDIOLOGY	0	807,507	0.000000	0.000000	3,116	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	16,320	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,284,477	0.000000	0.000000	73,048	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	586,074	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,097,243	0.000000	0.000000	295,083	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	13,027,361	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	707,012	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	70,530,208			1,336,613	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/21/2014 8:34 am

Title XIX | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
65.01	03950	SLEEP LAB	0	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,557	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,309	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)	1,751	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	96	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)	97	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	27	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)	28	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	752	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)	96	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)	97	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	126.36	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	126.36	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,095,370	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)	3,412	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)	3,538	25.00
26.00	Total swing-bed cost (see instructions)	245,185	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,850,185	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,850,185	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,234.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	928,254	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)	928,254	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	702,756	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,631,010	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	118,500	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	119,735	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	238,235	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	558	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,234.38	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	688,784	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	265,900	2,850,185	0.093292	688,784	64,258	90.00
91.00	Nursing School cost	0	2,850,185	0.000000	688,784	0	91.00
92.00	Allied health cost	0	2,850,185	0.000000	688,784	0	92.00
93.00	All other Medical Education	0	2,850,185	0.000000	688,784	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151301	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/21/2014 8:34 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,557	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,309	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)	1,751	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)	193	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	27	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)	28	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	52	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)	420	15.00
16.00	Nursery days (title V or XIX only)	311	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,095,370	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)	238,772	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,856,598	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,856,598	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,237.16	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	64,332	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)	64,332	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 8:34 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	464,364	420	1,105.63	311	343,851	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	340,128	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	748,311	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	558	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,237.16	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	690,335	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 8:34 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	265,900	2,856,598	0.093083	690,335	64,258	90.00
91.00	Nursing School cost	0	2,856,598	0.000000	690,335	0	91.00
92.00	Allied health cost	0	2,856,598	0.000000	690,335	0	92.00
93.00	All other Medical Education	0	2,856,598	0.000000	690,335	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		834,533		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.249962	313,737	78,422	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.834202	9,364	7,811	52.00
53.00	05300	ANESTHESIOLOGY	0.030619	16,184	496	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240081	39,260	9,426	54.00
57.00	05700	CT SCAN	0.021261	82,655	1,757	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.155834	6,945	1,082	58.00
60.00	06000	LABORATORY	0.151496	293,028	44,393	60.00
65.00	06500	RESPIRATORY THERAPY	0.415470	426,196	177,072	65.00
65.01	03950	SLEEP LAB	0.381302	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.516146	48,149	24,852	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.343430	14,044	4,823	67.00
69.00	06900	ELECTROCARDIOLOGY	0.303708	100,375	30,485	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.282475	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.268893	312,809	84,112	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.633167	78,830	49,913	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336732	546,786	184,120	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.259292	8,645	2,242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.974218	1,796	1,750	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,298,803	702,756	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		2,298,803		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151301 | Component CCN: 15Z301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.249962	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.834202	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.030619	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240081	0	0	54.00
57.00	05700	CT SCAN	0.021261	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.155834	0	0	58.00
60.00	06000	LABORATORY	0.151496	1,911	290	60.00
65.00	06500	RESPIRATORY THERAPY	0.415470	55,620	23,108	65.00
65.01	03950	SLEEP LAB	0.381302	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.516146	54,315	28,034	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.343430	11,360	3,901	67.00
69.00	06900	ELECTROCARDIOLOGY	0.303708	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.282475	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.268893	36,315	9,765	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.633167	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336732	61,422	20,683	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.259292	255	66	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.974218	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		221,198	85,847	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)		221,198		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/21/2014 8:34 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,536,754		30.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.249962	460,325	115,064	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.834202	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.030619	24,649	755	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240081	32,121	7,712	54.00
57.00	05700	CT SCAN	0.021261	30,233	643	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.155834	5,507	858	58.00
60.00	06000	LABORATORY	0.151496	289,833	43,909	60.00
65.00	06500	RESPIRATORY THERAPY	0.415470	118,419	49,200	65.00
65.01	03950	SLEEP LAB	0.381302	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.516146	3,275	1,690	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.343430	1,004	345	67.00
69.00	06900	ELECTROCARDIOLOGY	0.303708	3,116	946	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.282475	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.268893	73,048	19,642	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.633167	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336732	295,083	99,364	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.259292	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.974218	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,336,613	340,128	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)		1,336,613		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151301	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/21/2014 8:34 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,948,451	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)	3,948,451	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis 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)	3,987,936	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	35,565	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,897,339	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)	1,055,032	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)	1,055,032	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,055,032	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	537,058	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	472,611	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	399,578	36.00
37.00	Subtotal (see instructions)	1,527,643	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,527,643	40.00
40.01	Sequestration adjustment (see instructions)	30,553	40.01
41.00	Interim payments	2,060,165	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-563,075	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,461,936		1,765,965	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	01/09/2014	294,200	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		294,200	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)		1,461,936		2,060,165	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		58,120		563,075	6.02
7.00	Total Medicare program liability (see instructions)		1,403,816		1,497,090	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: 151301 | Component CCN: 15Z301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2014 8:34 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		334,062		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	01/29/2014	35,900		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		35,900		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		369,962		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		51,954		0	6.02
7.00	Total Medicare program liability (see instructions)		318,008		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: 151301 Component CCN: 15Z301	Period: From 07/01/2013 To 06/30/2014	Worksheet E-2 Date/Time Prepared: 11/21/2014 8:34 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	240,617	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 6 and 7, line 202 for Part B) (For CAH, see instructions)	86,705	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	193	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)	327,322	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	327,322	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)	327,322	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,824	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)	324,498	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
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)	324,498	0	19.00
19.01	Sequestration adjustment (see instructions)	6,490	0	19.01
20.00	Interim payments	369,962	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	-51,954	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: 151301	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part V Date/Time Prepared: 11/21/2014 8:34 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,631,010	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)	1,631,010	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,647,320	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,647,320	19.00
20.00	Deductibles (exclude professional component)	232,863	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,414,457	22.00
23.00	Coinsurance	1,216	23.00
24.00	Subtotal (line 22 minus line 23)	1,413,241	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	21,846	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	19,224	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,528	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,432,465	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	1,432,465	30.00
30.01	Sequestration adjustment (see instructions)	28,649	30.01
31.00	Interim payments	1,461,936	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	-58,120	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151301	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 11/21/2014 8:34 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	748,311		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	748,311	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	748,311	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	1,336,613	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,336,613	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,336,613	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	588,302	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	748,311	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	748,311	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	748,311	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	748,311	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	748,311	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	748,311	0	40.00
41.00	Interim payments	748,310	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	1	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G | Date/Time Prepared: 11/21/2014 8:34 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	20,299	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	8,922,499	0	0	0	4.00
5.00	Other receivable	3,038,726	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,728,598	0	0	0	6.00
7.00	Inventory	404,681	0	0	0	7.00
8.00	Prepaid expenses	17,554	0	0	0	8.00
9.00	Other current assets	-53,451	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,621,710	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	696,652	0	0	0	12.00
13.00	Land improvements	25,100	0	0	0	13.00
14.00	Accumulated depreciation	-24,224	0	0	0	14.00
15.00	Buildings	18,042,103	0	0	0	15.00
16.00	Accumulated depreciation	-7,371,778	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	592,548	0	0	0	19.00
20.00	Accumulated depreciation	-448,412	0	0	0	20.00
21.00	Automobiles and trucks	12,322	0	0	0	21.00
22.00	Accumulated depreciation	-11,882	0	0	0	22.00
23.00	Major movable equipment	5,450,953	0	0	0	23.00
24.00	Accumulated depreciation	-4,925,123	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,038,259	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	31,834,601	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	743,538	53,451	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	32,578,139	53,451	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	51,238,108	53,451	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,342,730	0	0	0	37.00
38.00	Salaries, wages, and fees payable	496,069	0	0	0	38.00
39.00	Payroll taxes payable	54,720	0	0	0	39.00
40.00	Notes and loans payable (short term)	204,804	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,460,048	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,558,371	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	14,109,989	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	52,717	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	14,162,706	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	19,721,077	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	31,517,031				52.00
53.00	Specific purpose fund		53,451			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	31,517,031	53,451	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	51,238,108	53,451	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-1 | Date/Time Prepared: 11/21/2014 8:34 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		24,070,489		65,263		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10,210,919				2.00
3.00	Total (sum of line 1 and line 2)		34,281,408		65,263		3.00
4.00	DEFERRED PENSION COST	146,895		0		0	4.00
5.00	DONATIONS	0		9,190		0	5.00
6.00	OTHER	0		114,831		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		146,895		124,021		10.00
11.00	Subtotal (line 3 plus line 10)		34,428,303		189,284		11.00
12.00	TRANSFERS TO AFFILIATES	2,790,503		0		0	12.00
13.00	OTHER PENSION RELATED ADJ	0		0		0	13.00
14.00	RELEASED OPERATING	0		135,833		0	14.00
15.00	RELEASED CAPITAL	120,769		0		0	15.00
16.00	ROUNDING	0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		2,911,272		135,833		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		31,517,031		53,451		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	DEFERRED PENSION COST		0			4.00
5.00	DONATIONS		0			5.00
6.00	OTHER		0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	TRANSFERS TO AFFILIATES		0			12.00
13.00	OTHER PENSION RELATED ADJ		0			13.00
14.00	RELEASED OPERATING		0			14.00
15.00	RELEASED CAPITAL		0			15.00
16.00	ROUNDING		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: 151301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/21/2014 8:34 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,123,647		5,123,647	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)	5,123,647		5,123,647	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,123,647		5,123,647	17.00
18.00	Ancillary services	6,021,008	49,841,596	55,862,604	18.00
19.00	Outpatient services	-34,159	13,776,296	13,742,137	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	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	0	0	0	26.00
27.00	OTHER	0	6,320	6,320	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,110,496	63,624,212	74,734,708	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,061,886		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		22,061,886		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151301	Period: From 07/01/2013 To 06/30/2014	Worksheet G-3 Date/Time Prepared: 11/21/2014 8:34 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	74,734,708	1.00
2.00	Less contractual allowances and discounts on patients' accounts	46,202,858	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,531,850	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,061,886	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,469,964	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	35,768	6.00
7.00	Income from investments	1,206,924	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	444,451	24.00
24.01	UNREALIZED GAINS	2,023,655	24.01
24.02	MISCELLANEOUS A&G	87	24.02
24.03	NET ASSETS RELEASED FROM RESTRICTION	30,651	24.03
25.00	Total other income (sum of lines 6-24)	3,741,536	25.00
26.00	Total (line 5 plus line 25)	10,211,500	26.00
27.00	LOSS ON INTEREST RATE SWAPS	581	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	581	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	10,210,919	29.00