

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/24/2014 2:07 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/24/2014	Time: 2:07 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARY'S WARRICK HOSPITAL, INC. (151325) 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 XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	140,151	-99,104	-27,994	0	1.00
2.00 Subprovider - IPF	0	755	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	155,458	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	296,364	-99,104	-27,994	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. 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: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/18/2014 10:51 am
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1.00 Hospital and Hospital Health Care Complex Address:		2.00		3.00		4.00				
1.00	Street: 1116 MILLIS AVE	PO Box:								
2.00	City: BOONEVILLE	State: IN	Zip Code: 47601	County: WARRICK						

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

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

						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2013	06/30/2014			20.00
21.00	Type of Control (see instructions)					1				21.00

22.00 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
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.							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.							25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/18/2014 10:51 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.	1			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.	1			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	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	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/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

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	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: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/18/2014 10:51 am																																																																																																																																																																				
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		1.00	2.00	3.00																																																																																																																																																																				
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(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)</td> <td></td> <td></td> <td></td> <td>N</td> <td>N 0</td> </tr> <tr> <td colspan="7">Inpatient Rehabilitation Facility PPS</td> </tr> <tr> <td>75.00</td> <td>Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td>76.00</td> <td>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. 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Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>86.00</td> <td>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.</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>Y</td> <td></td> <td>90.00</td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td>91.00</td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> <td></td> <td>92.00</td> </tr> <tr> <td>93.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td>93.00</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td>94.00</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td></td> <td>0.00</td> <td></td> <td>0.00</td> </tr> </tbody> </table> </td> </tr> </tbody> </table> </td></tr></tbody></table>									1.00	2.00	3.00	4.00	5.00	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.				Y		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. 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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.	Y	N	N	N	
		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:	8,362	0	0		
		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
DO NOT USE THIS LINE						
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/18/2014 10:51 am			
		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	158056	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. MARY'S HEALTH	Contractor's Name: WPS		Contractor's Number: 08101			
142.00	Street: 3700 WASHINGTON AVE.	PO Box:					
143.00	City: EVANSVILLE	State: IN		Zip Code: 47550			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00			
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N		145.00			
				1.00			
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 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
				1.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00			
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y		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)	388,298		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			
		Beginni ng 1.00		Endi ng 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)	07/01/2013		09/30/2013			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 11/18/2014 10:51 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	10/21/2014	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: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 11/18/2014 10:51 am	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			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.	CRYSTAL		HEATON	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. MARY'S HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	812-485-8483		CGHEATON@STMARYS.ORG	43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	10/21/2014		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: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
11/18/2014 10:51 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	26,400.00	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	26,400.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	26,400.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		35				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		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: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
11/18/2014 10:51 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	663	82	1,100			1.00
2.00 HMO and other (see instructions)	178	32				2.00
3.00 HMO IPF Subprovider	509	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	667	0	667			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	518			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,330	82	2,285			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	1,330	82	2,285	0.00	86.57	14.00
15.00 CAH visits	6,328	4,017	18,516			15.00
16.00 SUBPROVIDER - IPF	2,931	0	3,477	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	19.82	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	106.39	27.00
28.00 Observation Bed Days		0	382			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			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: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
11/18/2014 10:51 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	189	25	318	1.00
2.00 HMO and other (see instructions)			46	10		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	189	25	318	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	241	0	302	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
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: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-10

Date/Time Prepared:
11/18/2014 10:51 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)			0.402776	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			839,320	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00	
6.00	Medicaid charges			5,831,400	6.00	
7.00	Medicaid cost (line 1 times line 6)			2,348,748	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			1,509,428	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			6,892	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			1,509,428	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	503,041	342,117	845,158	20.00	
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	202,613	137,797	340,410	21.00	
22.00	Partial payment by patients approved for charity care	3,975	11,126	15,101	22.00	
23.00	Cost of charity care (line 21 minus line 22)	198,638	126,671	325,309	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?			N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2,638,504	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)			255,508	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			2,382,996	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			959,814	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,285,123	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,794,551	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet A

Date/Time Prepared:
11/18/2014 10:51 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		646,860	646,860	0	646,860	1.00
2.00	00200		196,122	196,122	0	196,122	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	-162,301	1,046,543	884,242	0	884,242	4.00
5.01	00540	0	22,228	22,228	0	22,228	5.01
5.02	00561	0	3,675	3,675	0	3,675	5.02
5.03	00550	365,981	350,298	716,279	0	716,279	5.03
5.04	00560	308,268	2,430,065	2,738,333	-184,614	2,553,719	5.04
6.00	00600	0	0	0	0	0	6.00
7.00	00700	153,931	530,218	684,149	0	684,149	7.00
8.00	00800	0	40,652	40,652	0	40,652	8.00
9.00	00900	0	237,076	237,076	0	237,076	9.00
10.00	01000	1,297	318,305	319,602	-42,085	277,517	10.00
11.00	01100	0	0	0	42,085	42,085	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	184,614	184,614	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	26,407	185,727	212,134	0	212,134	15.00
16.00	01600	54,490	75,231	129,721	0	129,721	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	952,176	117,767	1,069,943	0	1,069,943	30.00
31.00	03100	0	0	0	0	0	31.00
40.00	04000	901,483	539,013	1,440,496	0	1,440,496	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	211,132	199,203	410,335	0	410,335	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	163,023	163,023	0	163,023	53.00
54.00	05400	374,660	302,947	677,607	0	677,607	54.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	436,737	383,588	820,325	0	820,325	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	112,385	8,175	120,560	0	120,560	65.00
66.00	06600	246,255	49,000	295,255	0	295,255	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	2,618	17,687	20,305	246	20,551	69.00
71.00	07100	0	90,847	90,847	0	90,847	71.00
72.00	07200	0	3,508	3,508	0	3,508	72.00
73.00	07300	0	269,158	269,158	0	269,158	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	1,085,288	1,123,513	2,208,801	0	2,208,801	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		5,070,807	9,350,429	14,421,236	246	14,421,482	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	-349	2,939	2,590	-246	2,344	194.00
194.01	07951	74,429	22,308	96,737	0	96,737	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00		5,144,887	9,375,676	14,520,563	0	14,520,563	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet A
Date/Time Prepared:
11/18/2014 10:51 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	11,130	657,990	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-113,826	82,296	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	329,290	1,213,532	4.00
5.01	00540	NONPATIENT TELEPHONES	-1,065	21,163	5.01
5.02	00561	PURCHASING RECEIVING AND STORES	0	3,675	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	-58,519	657,760	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	-352,259	2,201,460	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-12,259	671,890	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	40,652	8.00
9.00	00900	HOUSEKEEPING	-8,040	229,036	9.00
10.00	01000	DIETARY	-35,107	242,410	10.00
11.00	01100	CAFETERIA	0	42,085	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	184,614	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	212,134	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	129,721	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-688	1,069,255	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	-4,652	1,435,844	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-125,871	284,464	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-157,600	5,423	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,825	674,782	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-395	819,930	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-330	120,230	65.00
66.00	06600	PHYSICAL THERAPY	-21,395	273,860	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-19,416	1,135	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	90,847	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,508	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	269,158	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-455,034	1,753,767	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,028,861	13,392,621	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	2,344	194.00
194.01	07951	OTHER NRCC - JAIL	0	96,737	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-1,028,861	13,491,702	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - NURSING ADMIN SALARIES					
1.00	NURSING ADMINISTRATION	13.00	184,614	0	1.00
	TOTALS		184,614	0	
B - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	0	41,914	1.00
2.00	CAFETERIA	11.00	171	0	2.00
	TOTALS		171	41,914	
C - EKG EXPENSE					
1.00	ELECTROCARDIOLOGY	69.00	0	595	1.00
2.00	OTHER NRCC - PHYSICIAN CLINIC	194.00	349	0	2.00
	TOTALS		349	595	
E - BENEFITS SAL TO OTHER					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	162,301	1.00
	TOTALS		0	162,301	
500.00	Grand Total: Increases		185,134	204,810	500.00

RECLASSIFICATIONS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-6

Date/Time Prepared:
11/18/2014 10:51 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - NURSING ADMIN SALARIES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	184,614	0	0	1.00
	TOTALS		184,614	0		
B - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	0	41,914	0	1.00
2.00	DIETARY	10.00	171	0	0	2.00
	TOTALS		171	41,914		
C - EKG EXPENSE						
1.00	OTHER NRCC - PHYSICIAN CLINIC	194.00	0	595	0	1.00
2.00	ELECTROCARDIOLOGY	69.00	349	0	0	2.00
	TOTALS		349	595		
E - BENEFITS SAL TO OTHER						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	162,301	0	0	1.00
	TOTALS		162,301	0		
500.00	Grand Total: Decreases		347,435	42,509		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-7
Part I
Date/Time Prepared:
11/18/2014 10:51 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	445,242	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,836,936	0	0	239,849	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	7,790,395	0	0	3,718	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,072,573	0	0	243,567	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	20,072,573	0	0	243,567	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	445,242	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	11,597,087	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	7,786,677	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	19,829,006	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	19,829,006	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-7
Part II
Date/Time Prepared:
11/18/2014 10:51 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	646,860	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	77,687	117,566	869	0	2.00
3.00	Total (sum of lines 1-2)	646,860	77,687	117,566	869	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	646,860				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	196,122				2.00
3.00	Total (sum of lines 1-2)	0	842,982				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet A-7 Part III Date/Time Prepared: 11/18/2014 10:51 am
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	11,597,087	0	11,597,087	0.598289	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,786,677	0	7,786,677	0.401711	0	2.00
3.00	Total (sum of lines 1-2)	19,383,764	0	19,383,764	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	657,990	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	11,072	77,687	2.00
3.00	Total (sum of lines 1-2)	0	0	0	669,062	77,687	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	657,990	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-7,332	869	0	0	82,296	2.00
3.00	Total (sum of lines 1-2)	-7,332	869	0	0	740,286	3.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
				Cost Center	Line #			
				3.00	4.00	5.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-36,680	0	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0	0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0	0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0	0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0	0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0	0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0	0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-757,167	0		0.00	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0	0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,060,444	0		0.00	0	12.00
13.00	Laundry and linen service		0	0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-33,328	0	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0	0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0	0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0	0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-20	0	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0	0		0.00	0	19.00
20.00	Vending machines	B	-1,779	0	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0	0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	RESPIRATORY THERAPY	65.00	0	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	PHYSICAL THERAPY	66.00	0	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	0	*** Cost Center Deleted ***	114.00	0	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	0	*** Cost Center Deleted ***	19.00	0	28.00
29.00	Physicians' assistant		0	0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	OCCUPATIONAL THERAPY	67.00	0	30.00
30.99	Hospice (non-distinct) (see instructions)		0	0	ADULTS & PEDIATRICS	30.00	0	30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0	SPEECH PATHOLOGY	68.00	0	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-75,847	0	CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	OTHER EXERCISE REVENUE	B	-21,170	0	PHYSICAL THERAPY	66.00	0	33.00
33.01	OTHER HOUSEKEEPING REVENUE	B	-8,040	0	HOUSEKEEPING	9.00	0	33.01

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.02 BUILDING RENTAL INCOME	B	-11,736	OPERATION OF PLANT	7.00	0	33.02
33.03 INCOME GENESIS	B	-1,640	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.03
33.04 PENSION ADJUSTMENT	A	329,290	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05 OTHER ADMIN REVENUE	B	-249	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.05
33.06 OTHER PLANT OPS REVENUE	B	-523	OPERATION OF PLANT	7.00	0	33.06
33.07 INVESTMENT REVENUE	B	-67,444	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.07
33.08		0		0.00	0	33.08
33.09 PHYSICIAN BILLING COSTS	A	-58,519	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	33.09
33.10		0		0.00	0	33.10
33.11 UNNECESSARY BORROWING	A	-57,454	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.11
33.12		0		0.00	0	33.12
33.13 TELEPHONE SERVICES	A	-1,065	NONPATIENT TELEPHONES	5.01	0	33.13
33.14		0		0.00	0	33.14
33.15 NON-ALLOWABLE COMMUNITY PROJECTS	A	-4,142	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.15
33.16		0		0.00	0	33.16
33.17		0		0.00	0	33.17
33.18 AHA LOBBYING	A	-495	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.18
33.19 NON-ALLOWABLE CED SALARIES	A	-4,529	SUBPROVIDER - IPF	40.00	0	33.19
33.20		0		0.00	0	33.20
33.21 PROVIDER TAX ADJUSTMENT	A	-1,276,768	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.21
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,028,861				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: 151325

Period: From 07/01/2013 To 06/30/2014

Worksheet A-8-1

Date/Time Prepared: 11/18/2014 10:51 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.04	OTHER ADMINISTRATIVE AND GEN	SMHS HO DIRECT COSTS	1,898,735	0 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	SMHS HO POOLED COSTS	86,977	0 2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	ASCENSION BOND AMORTIZATION	71,183	60,111 3.00
4.00	0.00			0	0 4.00
4.01	5.04	OTHER ADMINISTRATIVE AND GEN	MISSION HEALTH FEE	0	931,000 4.01
4.02	0.00			0	0 4.02
4.03	0.00			0	0 4.03
4.04	0.00			0	0 4.04
4.05	0.00			0	0 4.05
4.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS PASS THROUGH	6,903	6,903 4.06
4.07	5.01	NONPATIENT TELEPHONES	PHONES PASS THROUGH	20,774	20,774 4.07
4.08	5.04	OTHER ADMINISTRATIVE AND GEN	A&G PASS THROUGH	591,000	591,000 4.08
4.09	7.00	OPERATION OF PLANT	OPERATIONS PASS THROUGH	209,969	209,969 4.09
4.10	8.00	LAUNDRY & LINEN SERVICE	LINEN PASS THROUGH	40,652	40,652 4.10
4.11	15.00	PHARMACY	PHARMACY PASS THROUGH	47,226	47,226 4.11
4.12	60.00	LABORATORY	LAB PASS THROUGH	49,539	49,539 4.12
4.13	0.00			0	0 4.13
4.14	0.00			0	0 4.14
4.15	30.00	ADULTS & PEDIATRICS	TRIMEDX	26,784	27,472 4.15
4.16	40.00	SUBPROVIDER - IPF	TRIMEDX	4,775	4,898 4.16
4.17	50.00	OPERATING ROOM	TRIMEDX	28,445	29,176 4.17
4.18	0.00			0	0 4.18
4.19	54.00	RADIOLOGY-DIAGNOSTIC	TRIMEDX	109,834	112,659 4.19
4.20	60.00	LABORATORY	TRIMEDX	15,364	15,759 4.20
4.21	65.00	RESPIRATORY THERAPY	TRIMEDX	2,491	2,556 4.21
4.22	66.00	PHYSICAL THERAPY	TRIMEDX	8,720	8,945 4.22
4.23	91.00	EMERGENCY	TRIMEDX	11,212	11,500 4.23
4.24	0.00			0	0 4.24
5.00	0			3,230,583	2,170,139 5.00

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

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

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

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

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

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

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

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

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-8-1

Date/Time Prepared:
11/18/2014 10:51 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	1,898,735	0		1.00
2.00	86,977	9		2.00
3.00	11,072	9		3.00
4.00	0	0		4.00
4.01	-931,000	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	-688	0		4.15
4.16	-123	0		4.16
4.17	-731	0		4.17
4.18	0	0		4.18
4.19	-2,825	0		4.19
4.20	-395	0		4.20
4.21	-65	0		4.21
4.22	-225	0		4.22
4.23	-288	0		4.23
4.24	0	0		4.24
5.00	1,060,444			5.00

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

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-8-2

Date/Time Prepared:
11/18/2014 10:51 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,466,922	454,746	1,012,176	0	0	1.00
2.00	50.00	OPERATING ROOM	125,140	125,140	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	157,600	157,600	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	265	265	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	19,416	19,416	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,769,343	757,167	1,012,176	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	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	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	454,746		1.00
2.00	50.00	OPERATING ROOM	0	0	0	125,140		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	157,600		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	265		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	19,416		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	757,167		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151325		Period: From 07/01/2013 To 06/30/2014		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/18/2014 10:51 am	
		Physical Therapy				Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					26	1.00
2.00	Line 1 multiplied by 15 hours per week					390	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.21	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	208.00	536.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	96.31	77.05	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.53	38.53	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					20,032	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					41,299	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					61,331	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					61,331	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					61,331	23.00
Part III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151325				Period: From 07/01/2013 To 06/30/2014		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/18/2014 10:51 am	
		Physical Therapy				Cost			
						1.00			
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0		46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.05	0.00	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00	
						1.00			
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)					61,331		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0		59.00	
60.00	Overtime allowance (from column 5, line 56)					0		60.00	
61.00	Equipment cost (see instructions)					0		61.00	
62.00	Supplies (see instructions)					0		62.00	
63.00	Total allowance (sum of lines 57-62)					61,331		63.00	
64.00	Total cost of outside supplier services (from your records)					30,453		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0		65.00	
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					0		100.02	
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		101.01	
101.02	Line 34 = sum of lines 27 and 31					0		101.02	
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0		102.01	
102.02	Line 35 = sum of lines 31 and 32					0		102.02	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part I
Date/Time Prepared:
11/18/2014 10:51 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	657,990	657,990			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	82,296		82,296		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,213,532	6,220	778	1,220,530	4.00
5.01 00540	NONPATIENT TELEPHONES	21,163	2,831	354	0	24,348 5.01
5.02 00561	PURCHASING RECEIVING AND STORES	3,675	11,691	1,462	0	0 5.02
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE	657,760	20,909	2,615	84,167	2,649 5.03
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL	2,201,460	84,341	10,548	28,438	4,787 5.04
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	671,890	47,855	5,985	35,401	1,019 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	40,652	4,896	612	0	204 8.00
9.00 00900	HOUSEKEEPING	229,036	11,909	1,490	0	102 9.00
10.00 01000	DIETARY	242,410	27,800	3,477	259	407 10.00
11.00 01100	CAFETERIA	42,085	10,115	1,265	39	102 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	184,614	2,317	290	42,457	204 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	7,536	943	0	102 14.00
15.00 01500	PHARMACY	212,134	10,646	1,332	6,073	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	129,721	15,795	1,975	12,531	1,732 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,069,255	82,546	10,324	218,979	1,426 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
40.00 04000	SUBPROVIDER - I/PF	1,435,844	58,780	7,352	207,320	1,121 40.00
41.00 04100	SUBPROVIDER - I/RF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	284,464	51,174	6,400	48,556	1,426 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	5,423	784	98	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	674,782	39,866	4,986	86,163	1,630 54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	819,930	18,975	2,373	100,439	1,019 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	120,230	5,593	700	25,846	611 65.00
66.00 06600	PHYSICAL THERAPY	273,860	40,180	5,025	56,633	917 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	1,135	1,821	228	522	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	90,847	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	3,508	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	269,158	0	0	0	509 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	1,753,767	30,875	3,862	249,590	917 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	13,392,621	595,455	74,474	1,203,413	20,884 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,764	471	0	102 190.00
194.00 07950	OTHER NRCC - PHYSICIAN CLINIC	2,344	35,867	4,486	0	3,362 194.00
194.01 07951	OTHER NRCC - JAIL	96,737	0	0	17,117	0 194.01
194.02 07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0 194.02
194.03 07953	OTHER NRCC - DR. OFFICE	0	22,904	2,865	0	0 194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					0 201.00
202.00	TOTAL (sum lines 118-201)	13,491,702	657,990	82,296	1,220,530	24,348 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

Period: From 07/01/2013 To 06/30/2014

Worksheet B Part I Date/Time Prepared: 11/18/2014 10:51 am

Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00561	PURCHASING RECEIVING AND STORES	16,828					5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	4	768,104				5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	111	0	2,329,685	2,329,685		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,803	0	763,953	159,448		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	46,364	9,677	0	8.00
9.00	00900	HOUSEKEEPING	236	0	242,773	50,670	0	9.00
10.00	01000	DIETARY	1,015	0	275,368	57,473	0	10.00
11.00	01100	CAFETERIA	0	0	53,606	11,188	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	229,882	47,980	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	8,581	1,791	0	14.00
15.00	01500	PHARMACY	37	0	230,222	48,051	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	161,754	33,760	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,915	48,036	1,433,481	299,189	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - I/PF	2,580	110,554	1,823,551	380,602	0	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	951	23,495	416,466	86,923	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	162	2,629	9,096	1,898	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	162	121,492	929,081	193,913	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,617	93,652	1,040,005	217,065	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	79	13,367	166,426	34,736	0	65.00
66.00	06600	PHYSICAL THERAPY	218	44,383	421,216	87,914	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	665	8,496	12,867	2,686	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,805	109,652	22,886	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	423	3,931	820	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	60,679	330,346	68,948	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,212	222,093	2,263,316	472,395	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,767	768,104	13,301,622	2,290,013	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	4,337	905	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	61	0	46,120	9,626	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	113,854	23,763	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	25,769	5,378	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	16,828	768,104	13,491,702	2,329,685	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
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
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00561	PURCHASING RECEIVING AND STORES					5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	923,401				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,338	65,379			8.00
9.00	00900	HOUSEKEEPING	22,714	5,518	321,675		9.00
10.00	01000	DIETARY	53,023	0	0	385,864	10.00
11.00	01100	CAFETERIA	19,292	0	8,458	0	92,544
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,420	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,373	0	0	0	14.00
15.00	01500	PHARMACY	20,305	0	7,794	0	2,056
16.00	01600	MEDICAL RECORDS & LIBRARY	30,125	0	4,644	0	2,214
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	157,442	14,990	90,412	251,193	24,299
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
40.00	04000	SUBPROVIDER - IPF	112,110	15,536	85,380	134,671	21,757
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	97,604	4,115	8,403	0	4,429
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	1,495	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,036	7,294	12,051	0	9,079
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	36,190	0	10,503	0	10,308
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	10,668	3,000	5,528	0	2,063
66.00	06600	PHYSICAL THERAPY	76,634	0	0	0	4,366
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	3,473	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	58,888	14,403	47,043	0	11,971
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	804,130	64,856	280,216	385,864	92,542
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,178	0	4,035	0	0
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	68,409	523	26,866	0	2
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	6,357	0	0
194.03	07953	OTHER NRCC - DR. OFFICE	43,684	0	4,201	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	923,401	65,379	321,675	385,864	92,544

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

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Part I
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Cost Center Description			MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			12.00	13.00	14.00	15.00	16.00	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00561	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	282,282				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	24,745			14.00
15.00	01500	PHARMACY	0	0	0	308,428		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	232,497	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	77,705	0	375	14,540	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	69,573	0	39	33,463	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	14,162	0	698	7,112	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,616	796	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29,034	0	6,384	36,774	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	32,961	0	0	28,347	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,598	0	71	4,046	65.00
66.00	06600	PHYSICAL THERAPY	0	13,962	0	35	13,434	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	2,572	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	24,745	0	5,692	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	128	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	296,724	18,367	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	38,280	0	486	67,226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	282,275	24,745	308,428	232,497	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	7	0	0	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	282,282	24,745	308,428	232,497	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part I
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	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
5.01	00540	NONPATIENT TELEPHONES				5.01
5.02	00561	PURCHASING RECEIVING AND STORES				5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,363,626	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
40.00	04000	SUBPROVIDER - I PF	0	2,676,682	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	639,912	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	16,901	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,299,646	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	1,375,379	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	233,136	0	65.00
66.00	06600	PHYSICAL THERAPY	0	617,561	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	21,598	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	162,975	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,879	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	714,385	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,974,008	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	13,100,688	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,455	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	151,553	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	137,617	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	6,357	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	79,032	0	194.03
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)	0	13,491,702	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

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Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
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	6,220	778	6,998	4.00
5.01 00540	NONPATIENT TELEPHONES	308	2,831	354	3,493	5.01
5.02 00561	PURCHASING RECEIVING AND STORES	0	11,691	1,462	13,153	5.02
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE	25,446	20,909	2,615	48,970	5.03
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL	71	84,341	10,548	94,960	5.04
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	65,617	47,855	5,985	119,457	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,896	612	5,508	8.00
9.00 00900	HOUSEKEEPING	0	11,909	1,490	13,399	9.00
10.00 01000	DIETARY	699	27,800	3,477	31,976	10.00
11.00 01100	CAFETERIA	0	10,115	1,265	11,380	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	2,317	290	2,607	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	7,536	943	8,479	14.00
15.00 01500	PHARMACY	215	10,646	1,332	12,193	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	273	15,795	1,975	18,043	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,444	82,546	10,324	99,314	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00 04000	SUBPROVIDER - IPF	3,900	58,780	7,352	70,032	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	701	51,174	6,400	58,275	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	1,629	784	98	2,511	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,013	39,866	4,986	46,865	54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	3,651	18,975	2,373	24,999	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	789	5,593	700	7,082	65.00
66.00 06600	PHYSICAL THERAPY	732	40,180	5,025	45,937	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	1,821	228	2,049	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	985	30,875	3,862	35,722	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	113,473	595,455	74,474	783,402	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,764	471	4,235	190.00
194.00 07950	OTHER NRCC - PHYSICIAN CLINIC	2,012	35,867	4,486	42,365	194.00
194.01 07951	OTHER NRCC - JAIL	0	0	0	0	194.01
194.02 07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	194.02
194.03 07953	OTHER NRCC - DR. OFFICE	0	22,904	2,865	25,769	194.03
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	115,485	657,990	82,296	855,771	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		NONPATIENT TELEPHONES	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
		5.01	5.02	5.03	5.04	6.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540	3,493					5.01
5.02	00561	0	13,153				5.02
5.03	00550	380	4	49,837			5.03
5.04	00560	685	87	0	95,895		5.04
6.00	00600	0	0	0	0	0	6.00
7.00	00700	146	1,409	0	6,563	0	7.00
8.00	00800	29	0	0	398	0	8.00
9.00	00900	15	185	0	2,086	0	9.00
10.00	01000	58	793	0	2,366	0	10.00
11.00	01100	15	0	0	461	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	29	0	0	1,975	0	13.00
14.00	01400	15	0	0	74	0	14.00
15.00	01500	0	29	0	1,978	0	15.00
16.00	01600	248	0	0	1,390	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	205	2,279	3,116	12,315	0	30.00
31.00	03100	0	0	0	0	0	31.00
40.00	04000	161	2,016	7,172	15,666	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	205	744	1,524	3,578	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	126	171	78	0	53.00
54.00	05400	234	126	7,882	7,982	0	54.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	146	2,826	6,076	8,935	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	88	62	867	1,430	0	65.00
66.00	06600	132	171	2,879	3,619	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	520	551	111	0	69.00
71.00	07100	0	0	1,220	942	0	71.00
72.00	07200	0	0	27	34	0	72.00
73.00	07300	73	0	3,936	2,838	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	132	1,729	14,416	19,444	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		2,996	13,106	49,837	94,263	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	15	0	0	37	0	190.00
194.00	07950	482	47	0	396	0	194.00
194.01	07951	0	0	0	978	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	221	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		3,493	13,153	49,837	95,895	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part II Date/Time Prepared: 11/18/2014 10:51 am			
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		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
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00561	PURCHASING RECEIVING AND STORES					5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	127,778				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,292	7,227			8.00
9.00	00900	HOUSEKEEPING	3,143	610	19,438		9.00
10.00	01000	DIETARY	7,337	0	0	42,531	10.00
11.00	01100	CAFETERIA	2,670	0	511	0	15,037
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	612	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,989	0	0	0	14.00
15.00	01500	PHARMACY	2,810	0	471	0	334
16.00	01600	MEDICAL RECORDS & LIBRARY	4,169	0	281	0	360
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,785	1,657	5,463	27,687	3,949
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
40.00	04000	SUBPROVIDER - IPF	15,514	1,717	5,159	14,844	3,535
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	13,506	455	508	0	720
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	207	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,522	806	728	0	1,475
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	5,008	0	635	0	1,675
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,476	332	334	0	335
66.00	06600	PHYSICAL THERAPY	10,604	0	0	0	709
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	481	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	8,149	1,592	2,843	0	1,945
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	111,274	7,169	16,933	42,531	15,037
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	993	0	244	0	0
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	9,466	58	1,623	0	0
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	384	0	0
194.03	07953	OTHER NRCC - DR. OFFICE	6,045	0	254	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	127,778	7,227	19,438	42,531	15,037

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part II
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Cost Center Description			MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			12.00	13.00	14.00	15.00	16.00	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00561	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	5,467				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	10,557			14.00
15.00	01500	PHARMACY	0	0	0	17,850		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	24,563	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,507	0	22	1,536	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	1,347	0	2	3,535	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	274	0	40	751	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	209	84	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	562	0	369	3,884	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	638	0	0	2,994	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	128	0	4	427	65.00
66.00	06600	PHYSICAL THERAPY	0	270	0	2	1,419	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	272	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	10,557	0	601	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	14	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,174	1,940	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	741	0	28	7,106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	5,467	10,557	17,850	24,563	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	5,467	10,557	17,850	24,563	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part II
Date/Time Prepared:
11/18/2014 10:51 am

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.01	00540					5.01
5.02	00561					5.02
5.03	00550					5.03
5.04	00560					5.04
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
12.00	01200					12.00
13.00	01300					13.00
14.00	01400					14.00
15.00	01500					15.00
16.00	01600					16.00
17.00	01700	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	0	182,091	0	182,091	30.00
31.00	03100	0	0	0	0	31.00
40.00	04000	0	141,889	0	141,889	40.00
41.00	04100	0	0	0	0	41.00
42.00	04200	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	80,858	0	80,858	50.00
51.00	05100	0	0	0	0	51.00
52.00	05200	0	0	0	0	52.00
53.00	05300	0	3,386	0	3,386	53.00
54.00	05400	0	81,929	0	81,929	54.00
56.00	05600	0	0	0	0	56.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
59.00	05900	0	0	0	0	59.00
60.00	06000	0	54,508	0	54,508	60.00
60.01	06001	0	0	0	0	60.01
63.00	06300	0	0	0	0	63.00
64.00	06400	0	0	0	0	64.00
65.00	06500	0	12,713	0	12,713	65.00
66.00	06600	0	66,067	0	66,067	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
69.00	06900	0	3,987	0	3,987	69.00
71.00	07100	0	13,320	0	13,320	71.00
72.00	07200	0	75	0	75	72.00
73.00	07300	0	25,961	0	25,961	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	0	0	0	0	90.00
91.00	09100	0	95,277	0	95,277	91.00
92.00	09200	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00		0	762,061	0	762,061	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	5,524	0	5,524	190.00
194.00	07950	0	54,437	0	54,437	194.00
194.01	07951	0	1,076	0	1,076	194.01
194.02	07952	0	384	0	384	194.02
194.03	07953	0	32,289	0	32,289	194.03
200.00		0	0	0	0	200.00
201.00		0	0	0	0	201.00
202.00		0	855,771	0	855,771	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet B-1

Date/Time Prepared:
11/18/2014 10:51 am

Cost Center Description	CAPITAL RELATED COSTS					EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NONPATIENT TELEPHONES)	PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)							
	1.00	2.00	4.00	5.01	5.02				
GENERAL SERVICE COST CENTERS									
1.00 00100	CAP REL COSTS-BLDG & FIXT	75,527							1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		75,527						2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	714	714	5,307,188					4.00
5.01 00540	NONPATIENT TELEPHONES	325	325	0	239				5.01
5.02 00561	PURCHASING RECEIVING AND STORES	1,342	1,342	0	0	22,500			5.02
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE	2,400	2,400	365,981	26	6			5.03
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL	9,681	9,681	123,654	47	149			5.04
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0			6.00
7.00 00700	OPERATION OF PLANT	5,493	5,493	153,931	10	2,411			7.00
8.00 00800	LAUNDRY & LINEN SERVICE	562	562	0	2	0			8.00
9.00 00900	HOUSEKEEPING	1,367	1,367	0	1	316			9.00
10.00 01000	DIETARY	3,191	3,191	1,126	4	1,357			10.00
11.00 01100	CAFETERIA	1,161	1,161	171	1	0			11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0			12.00
13.00 01300	NURSING ADMINISTRATION	266	266	184,614	2	0			13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	865	865	0	1	0			14.00
15.00 01500	PHARMACY	1,222	1,222	26,407	0	50			15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,813	1,813	54,490	17	0			16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00 03000	ADULTS & PEDIATRICS	9,475	9,475	952,176	14	3,898			30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0			31.00
40.00 04000	SUBPROVIDER - I/PF	6,747	6,747	901,483	11	3,449			40.00
41.00 04100	SUBPROVIDER - I/RF	0	0	0	0	0			41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0			42.00
ANCILLARY SERVICE COST CENTERS									
50.00 05000	OPERATING ROOM	5,874	5,874	211,132	14	1,272			50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0			51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0			52.00
53.00 05300	ANESTHESIOLOGY	90	90	0	0	216			53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,576	4,576	374,660	16	216			54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0			56.00
57.00 05700	CT SCAN	0	0	0	0	0			57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0			58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0			59.00
60.00 06000	LABORATORY	2,178	2,178	436,737	10	4,834			60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0			60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0			63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0			64.00
65.00 06500	RESPIRATORY THERAPY	642	642	112,385	6	106			65.00
66.00 06600	PHYSICAL THERAPY	4,612	4,612	246,255	9	292			66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0			67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0			68.00
69.00 06900	ELECTROCARDIOLOGY	209	209	2,269	0	889			69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0			71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0			72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	5	0			73.00
OUTPATIENT SERVICE COST CENTERS									
90.00 09000	CLINIC	0	0	0	0	0			90.00
91.00 09100	EMERGENCY	3,544	3,544	1,085,288	9	2,958			91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)								92.00
SPECIAL PURPOSE COST CENTERS									
118.00	SUBTOTALS (SUM OF LINES 1-117)	68,349	68,349	5,232,759	205	22,419			118.00
NONREIMBURSABLE COST CENTERS									
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	432	432	0	1	0			190.00
194.00 07950	OTHER NRCC - PHYSICIAN CLINIC	4,117	4,117	0	33	81			194.00
194.01 07951	OTHER NRCC - JAIL	0	0	74,429	0	0			194.01
194.02 07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0			194.02
194.03 07953	OTHER NRCC - DR. OFFICE	2,629	2,629	0	0	0			194.03
200.00	Cross Foot Adjustments								200.00
201.00	Negative Cost Centers								201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	657,990	82,296	1,220,530		24,348	16,828		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8.711984	1.089624	0.229977	101.874477	0.747911			203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			6,998	3,493	13,153			204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001319	14.615063	0.584578			205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet B-1

Date/Time Prepared:
11/18/2014 10:51 am

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (ASSIGNED TIME)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5A.04	5.04	6.00	7.00	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00561	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	32,526,018					5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	-2,329,685	11,162,017			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	0	763,953	0	55,572	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	46,364	0	562	8.00
9.00	00900	HOUSEKEEPING	0	0	242,773	0	1,367	9.00
10.00	01000	DIETARY	0	0	275,368	0	3,191	10.00
11.00	01100	CAFETERIA	0	0	53,606	0	1,161	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	229,882	0	266	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	8,581	0	865	14.00
15.00	01500	PHARMACY	0	0	230,222	0	1,222	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	161,754	0	1,813	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,034,139	0	1,433,481	0	9,475	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - I PF	4,681,495	0	1,823,551	0	6,747	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	994,914	0	416,466	0	5,874	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	111,322	0	9,096	0	90	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,144,675	0	929,081	0	4,576	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,965,789	0	1,040,005	0	2,178	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	566,048	0	166,426	0	642	65.00
66.00	06600	PHYSICAL THERAPY	1,879,456	0	421,216	0	4,612	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	359,770	0	12,867	0	209	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	796,295	0	109,652	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,904	0	3,931	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,569,511	0	330,346	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	9,404,700	0	2,263,316	0	3,544	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,526,018	-2,329,685	10,971,937	0	48,394	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	4,337	0	432	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	0	46,120	0	4,117	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	113,854	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	25,769	0	2,629	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	768,104		2,329,685	0	923,401	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.023615		0.208715	0.000000	16.616300	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	49,837		95,895	0	127,778	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001532		0.008591	0.000000	2.299323	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet B-1

Date/Time Prepared:
11/18/2014 10:51 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	
		8.00	9.00	10.00	11.00	12.00	
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
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00561	PURCHASING RECEIVING AND STORES					5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,375				8.00
9.00	00900	HOUSEKEEPING	960	58,190			9.00
10.00	01000	DIETARY	0	0	30,469		10.00
11.00	01100	CAFETERIA	0	1,530	0	175,337	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	1,410	0	3,895	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	840	0	4,195	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,608	16,355	19,835	46,039	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - I/PF	2,703	15,445	10,634	41,221	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	716	1,520	0	8,391	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,269	2,180	0	17,202	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	1,900	0	19,529	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	522	1,000	0	3,909	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,272	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,506	8,510	0	22,680	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,284	50,690	30,469	175,333	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	730	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	91	4,860	0	4	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	1,150	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	760	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	65,379	321,675	385,864	92,544	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.747604	5.528012	12.664150	0.527806	0.000000
204.00		Cost to be allocated (per Wkst. B, Part II)	7,227	19,438	42,531	15,037	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.635341	0.334044	1.395878	0.085761	0.000000

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet B-1

Date/Time Prepared:
11/18/2014 10:51 am

Cost Center Description			NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00561	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION	167,247					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100				14.00
15.00	01500	PHARMACY	0	0	270,419			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	32,526,018		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	46,039	0	329	2,034,139	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - I/PF	41,221	0	34	4,681,495	0	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,391	0	612	994,914	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	3,170	111,322	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,202	0	5,597	5,144,675	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	19,529	0	0	3,965,789	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,909	0	62	566,048	0	65.00
66.00	06600	PHYSICAL THERAPY	8,272	0	31	1,879,456	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	359,770	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100	0	796,295	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,904	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	260,158	2,569,511	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	22,680	0	426	9,404,700	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	167,243	100	270,419	32,526,018		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	4	0	0	0	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	282,282	24,745	308,428	232,497		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.687815	247.450000	1.140556	0.007148	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,467	10,557	17,850	24,563		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.032688	105.570000	0.066009	0.000755	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet C
Part I
Date/Time Prepared:
11/18/2014 10:51 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	2,363,626	2,363,626	0	2,363,626	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000 SUBPROVIDER - IPF	2,676,682	2,676,682	0	2,676,682	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	639,912	639,912	0	639,912	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	16,901	16,901	0	16,901	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,299,646	1,299,646	0	1,299,646	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000 LABORATORY	1,375,379	1,375,379	0	1,375,379	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	233,136	233,136	0	233,136	65.00
66.00	06600 PHYSICAL THERAPY	617,561	617,561	0	617,561	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	21,598	21,598	0	21,598	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	162,975	162,975	0	162,975	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4,879	4,879	0	4,879	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	714,385	714,385	0	714,385	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0	0	90.00
91.00	09100 EMERGENCY	2,974,008	2,974,008	0	2,974,008	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	408,518	408,518	0	408,518	92.00
200.00	Subtotal (see instructions)	13,509,206	13,509,206	0	13,509,206	200.00
201.00	Less Observation Beds	408,518	408,518	0	408,518	201.00
202.00	Total (see instructions)	13,100,688	13,100,688	0	13,100,688	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet C
Part I
Date/Time Prepared:
11/18/2014 10:51 am

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,761,012		1,761,012		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
40.00	04000	SUBPROVIDER - IPF	4,681,495		4,681,495		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	152,723	842,191	994,914	0.643183	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	15,438	95,884	111,322	0.151821	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,146,702	3,997,973	5,144,675	0.252620	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,128,391	2,837,398	3,965,789	0.346811	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	352,987	213,061	566,048	0.411866	65.00
66.00	06600	PHYSICAL THERAPY	712,683	1,166,773	1,879,456	0.328585	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	116,312	243,458	359,770	0.060033	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	376,867	419,428	796,295	0.204667	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,904	17,904	0.272509	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,356,208	1,213,303	2,569,511	0.278024	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	3,866,889	5,537,811	9,404,700	0.316226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	273,127	273,127	1.495707	92.00
200.00		Subtotal (see instructions)	15,667,707	16,858,311	32,526,018		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,667,707	16,858,311	32,526,018		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/18/2014 10:51 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
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.643183		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.151821		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.252620		54.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.346811		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.411866		65.00
66.00	06600 PHYSICAL THERAPY	0.328585		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.060033		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.204667		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.272509		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.278024		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.316226		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.495707		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet C
Part I
Date/Time Prepared:
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		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		2,363,626	0	2,363,626	30.00
31.00	03100 INTENSIVE CARE UNIT		0	0	0	31.00
40.00	04000 SUBPROVIDER - IPF		2,676,682	0	2,676,682	40.00
41.00	04100 SUBPROVIDER - IRF		0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		639,912	0	639,912	50.00
51.00	05100 RECOVERY ROOM		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY		16,901	0	16,901	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,299,646	0	1,299,646	54.00
56.00	05600 RADIOISOTOPE		0	0	0	56.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		1,375,379	0	1,375,379	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	233,136	0	233,136	65.00
66.00	06600 PHYSICAL THERAPY	0	617,561	0	617,561	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY		21,598	0	21,598	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		162,975	0	162,975	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		4,879	0	4,879	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		714,385	0	714,385	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0	0	0	90.00
91.00	09100 EMERGENCY		2,974,008	0	2,974,008	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		408,518	0	408,518	92.00
200.00	Subtotal (see instructions)	0	13,509,206	0	13,509,206	200.00
201.00	Less Observation Beds		408,518	0	408,518	201.00
202.00	Total (see instructions)	0	13,100,688	0	13,100,688	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet C
Part I
Date/Time Prepared:
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		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,761,012		1,761,012		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
40.00	04000	SUBPROVIDER - IPF	4,681,495		4,681,495		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	152,723	842,191	994,914	0.643183	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	15,438	95,884	111,322	0.151821	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,146,702	3,997,973	5,144,675	0.252620	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,128,391	2,837,398	3,965,789	0.346811	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	352,987	213,061	566,048	0.411866	65.00
66.00	06600	PHYSICAL THERAPY	712,683	1,166,773	1,879,456	0.328585	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	116,312	243,458	359,770	0.060033	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	376,867	419,428	796,295	0.204667	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,904	17,904	0.272509	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,356,208	1,213,303	2,569,511	0.278024	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	3,866,889	5,537,811	9,404,700	0.316226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	273,127	273,127	1.495707	92.00
200.00		Subtotal (see instructions)	15,667,707	16,858,311	32,526,018		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,667,707	16,858,311	32,526,018		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/18/2014 10:51 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
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 151325

Period: From 07/01/2013 To 06/30/2014

Worksheet C Part II Date/Time Prepared: 11/18/2014 10:51 am

Cost Center Description		Title XIX			Hospital Cost		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	639,912	80,858	559,054	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	16,901	3,386	13,515	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,299,646	81,929	1,217,717	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	1,375,379	54,508	1,320,871	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	233,136	12,713	220,423	0	0	65.00
66.00	06600 PHYSICAL THERAPY	617,561	66,067	551,494	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	21,598	3,987	17,611	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	162,975	13,320	149,655	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4,879	75	4,804	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	714,385	25,961	688,424	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	2,974,008	95,277	2,878,731	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	408,518	46,936	361,582	0	0	92.00
200.00	Subtotal (sum of lines 50 thru 199)	8,468,898	485,017	7,983,881	0	0	200.00
201.00	Less Observation Beds	408,518	46,936	361,582	0	0	201.00
202.00	Total (line 200 minus line 201)	8,060,380	438,081	7,622,299	0	0	202.00

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

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet C
Part II
Date/Time Prepared:
11/18/2014 10:51 am

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)	Title XIX	
					Hospital	Cost
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	639,912	994,914	0.643183		50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	16,901	111,322	0.151821		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,299,646	5,144,675	0.252620		54.00
56.00	05600 RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700 CT SCAN	0	0	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000 LABORATORY	1,375,379	3,965,789	0.346811		60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000		63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	233,136	566,048	0.411866		65.00
66.00	06600 PHYSICAL THERAPY	617,561	1,879,456	0.328585		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	21,598	359,770	0.060033		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	162,975	796,295	0.204667		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4,879	17,904	0.272509		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	714,385	2,569,511	0.278024		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0.000000		90.00
91.00	09100 EMERGENCY	2,974,008	9,404,700	0.316226		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	408,518	273,127	1.495707		92.00
200.00	Subtotal (sum of lines 50 thru 199)	8,468,898	26,083,511			200.00
201.00	Less Observation Beds	408,518	0			201.00
202.00	Total (line 200 minus line 201)	8,060,380	26,083,511			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part II Date/Time Prepared: 11/18/2014 10:51 am
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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	80,858	994,914	0.081271	22,752	1,849	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	3,386	111,322	0.030416	1,992	61	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	81,929	5,144,675	0.015925	61,187	974	54.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	54,508	3,965,789	0.013745	174,548	2,399	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	12,713	566,048	0.022459	114,716	2,576	65.00
66.00	06600 PHYSICAL THERAPY	66,067	1,879,456	0.035152	44,255	1,556	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	3,987	359,770	0.011082	45,400	503	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13,320	796,295	0.016727	120,670	2,018	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	75	17,904	0.004189	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	25,961	2,569,511	0.010103	290,912	2,939	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	95,277	9,404,700	0.010131	2,260	23	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	46,936	273,127	0.171847	0	0	92.00
200.00	Total (lines 50-199)	485,017	26,083,511		878,692	14,898	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part IV
Date/Time Prepared:
11/18/2014 10:51 am

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part IV
Date/Time Prepared:
11/18/2014 10:51 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	994,914	0.000000	0.000000	22,752	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	111,322	0.000000	0.000000	1,992	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,144,675	0.000000	0.000000	61,187	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	3,965,789	0.000000	0.000000	174,548	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	566,048	0.000000	0.000000	114,716	65.00
66.00	06600	PHYSICAL THERAPY	0	1,879,456	0.000000	0.000000	44,255	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	359,770	0.000000	0.000000	45,400	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	796,295	0.000000	0.000000	120,670	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,904	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,569,511	0.000000	0.000000	290,912	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	9,404,700	0.000000	0.000000	2,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	273,127	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	26,083,511			878,692	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part IV
Date/Time Prepared:
11/18/2014 10:51 am

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)	Hospital	Cost
		11.00	12.00	13.00		
Title XVIII						
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
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
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
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						
90.00	09000	CLINIC	0	0	0	90.00
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: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/18/2014 10:51 am
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges	Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.643183	0	288,845	0	0
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00	05300 ANESTHESIOLOGY	0.151821	0	40,836	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.252620	0	1,193,810	0	0
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0
57.00	05700 CT SCAN	0.000000	0	0	0	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00	06000 LABORATORY	0.346811	0	1,201,582	0	0
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0
65.00	06500 RESPIRATORY THERAPY	0.411866	0	213,061	0	0
66.00	06600 PHYSICAL THERAPY	0.328585	0	246,970	0	0
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY	0.060033	0	232,132	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.204667	0	199,092	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.272509	0	17,904	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.278024	0	446,074	854	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.000000	0	0	0	0
91.00	09100 EMERGENCY	0.316226	0	1,631,096	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.495707	0	227,194	0	0
200.00	Subtotal (see instructions)		0	5,938,596	854	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (Line 200 +/- Line 201)		0	5,938,596	854	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/18/2014 10:51 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	185,780	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	6,200	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	301,580	0		54.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	416,722	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	87,753	0		65.00
66.00 06600 PHYSICAL THERAPY	81,151	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	13,936	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	40,748	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4,879	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	124,019	237		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	515,795	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	339,816	0		92.00
200.00 Subtotal (see instructions)	2,118,379	237		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (Line 200 +/- Line 201)	2,118,379	237		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151325 Component CCN: 15M325		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part II Date/Time Prepared: 11/18/2014 10:51 am		
		Title XVIII		Subprovider - IPF		PPS		
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	80,858	994,914	0.081271	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,386	111,322	0.030416	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,929	5,144,675	0.015925	88,780	1,414	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	54,508	3,965,789	0.013745	333,374	4,582	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,713	566,048	0.022459	45,029	1,011	65.00
66.00	06600	PHYSICAL THERAPY	66,067	1,879,456	0.035152	82,352	2,895	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,987	359,770	0.011082	66,886	741	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,320	796,295	0.016727	48,100	805	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	75	17,904	0.004189	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,961	2,569,511	0.010103	389,346	3,934	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	95,277	9,404,700	0.010131	94	1	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	273,127	0.000000	0	0	92.00
200.00		Total (lines 50-199)	438,081	26,083,511		1,053,961	15,383	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/18/2014 10:51 am
Title XVIII		Subprovider - IPF	PPS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/18/2014 10:51 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)	
	6.00	7.00	8.00	9.00	10.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	994,914	0.000000	0.000000	0 50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000	0.000000	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0 52.00
53.00 05300 ANESTHESIOLOGY	0	111,322	0.000000	0.000000	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	5,144,675	0.000000	0.000000	88,780 54.00
56.00 05600 RADIOISOTOPE	0	0	0.000000	0.000000	0 56.00
57.00 05700 CT SCAN	0	0	0.000000	0.000000	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0 59.00
60.00 06000 LABORATORY	0	3,965,789	0.000000	0.000000	333,374 60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0 60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0 63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0 64.00
65.00 06500 RESPIRATORY THERAPY	0	566,048	0.000000	0.000000	45,029 65.00
66.00 06600 PHYSICAL THERAPY	0	1,879,456	0.000000	0.000000	82,352 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0 67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0	359,770	0.000000	0.000000	66,886 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	796,295	0.000000	0.000000	48,100 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	17,904	0.000000	0.000000	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,569,511	0.000000	0.000000	389,346 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	0	0.000000	0.000000	0 90.00
91.00 09100 EMERGENCY	0	9,404,700	0.000000	0.000000	94 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	273,127	0.000000	0.000000	0 92.00
200.00 Total (lines 50-199)	0	26,083,511			1,053,961 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/18/2014 10:51 am
	Component CCN: 15M325	Title XVIII	Subprovider - IPF PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
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
56.00	05600 RADIOISOTOPE	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
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					
90.00	09000 CLINIC	0	0	0	90.00
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: 151325 Component CCN: 15Z325	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/18/2014 10:51 am
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.643183	0	0	0	0
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00	05300 ANESTHESIOLOGY	0.151821	0	0	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.252620	0	0	0	0
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0
57.00	05700 CT SCAN	0.000000	0	0	0	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00	06000 LABORATORY	0.346811	0	0	0	0
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0
65.00	06500 RESPIRATORY THERAPY	0.411866	0	0	0	0
66.00	06600 PHYSICAL THERAPY	0.328585	0	0	0	0
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY	0.060033	0	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.204667	0	0	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.272509	0	0	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.278024	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.000000	0	0	0	0
91.00	09100 EMERGENCY	0.316226	0	0	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.495707	0	0	0	0
200.00	Subtotal (see instructions)		0	0	0	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00	Net Charges (Line 200 +/- Line 201)		0	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151325 Component CCN: 15Z325	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/18/2014 10:51 am
	Title XVIII	Swing Beds - SNF	Cost

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part I Date/Time Prepared: 11/18/2014 10:51 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	182,091	59,994	122,097	1,482	82.39	30.00	
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00	
40.00	SUBPROVIDER - IPF	141,889	0	141,889	3,477	40.81	40.00	
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00	
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00	
200.00	Total (lines 30-199)	323,980		263,986	4,959		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	82	6,756					30.00
31.00	INTENSIVE CARE UNIT	0	0					31.00
40.00	SUBPROVIDER - IPF	0	0					40.00
41.00	SUBPROVIDER - IRF	0	0					41.00
42.00	SUBPROVIDER	0	0					42.00
200.00	Total (lines 30-199)	82	6,756					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part II
Date/Time Prepared:
11/18/2014 10:51 am

Cost Center Description		Title XIX			Hospital	Cost		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	80,858	994,914	0.081271	128,472	10,441	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,386	111,322	0.030416	13,446	409	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,929	5,144,675	0.015925	977,411	15,565	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	54,508	3,965,789	0.013745	531,736	7,309	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,713	566,048	0.022459	71,176	1,599	65.00
66.00	06600	PHYSICAL THERAPY	66,067	1,879,456	0.035152	83,436	2,933	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,987	359,770	0.011082	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,320	796,295	0.016727	94,810	1,586	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	75	17,904	0.004189	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,961	2,569,511	0.010103	237,375	2,398	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	95,277	9,404,700	0.010131	3,864,535	39,152	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	46,936	273,127	0.171847	0	0	92.00
200.00		Total (lines 50-199)	485,017	26,083,511		6,002,397	81,392	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151325		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part III Date/Time Prepared: 11/18/2014 10:51 am	
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
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,482	0.00	82	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,477	0.00	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	0	42.00
200.00		Total (lines 30-199)	4,959		82	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part IV
Date/Time Prepared:
11/18/2014 10:51 am

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	Cost
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	994,914	0.000000	0.000000	128,472	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	111,322	0.000000	0.000000	13,446	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,144,675	0.000000	0.000000	977,411	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	3,965,789	0.000000	0.000000	531,736	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	566,048	0.000000	0.000000	71,176	65.00
66.00	06600	PHYSICAL THERAPY	0	1,879,456	0.000000	0.000000	83,436	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	359,770	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	796,295	0.000000	0.000000	94,810	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,904	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,569,511	0.000000	0.000000	237,375	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	9,404,700	0.000000	0.000000	3,864,535	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	273,127	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	26,083,511			6,002,397	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part IV
Date/Time Prepared:
11/18/2014 10:51 am

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)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
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
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
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						
90.00	09000 CLINIC	0	0	0		90.00
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: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 11/18/2014 10:51 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,667	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,482	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)		1,100	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		334	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)		333	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		259	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)		259	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		663	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)		334	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)		333	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		126.36	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		126.36	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,363,626	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)		32,727	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)		32,727	25.00
26.00	Total swing-bed cost (see instructions)		778,750	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,584,876	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)		1,584,876	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)		1,069.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		709,019	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)		709,019	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/18/2014 10:51 am	
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)
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00
Intensive Care Type Inpatient Hospital Units						
42.00						42.00
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					261,736
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					970,755
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					357,183
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					356,114
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					713,297
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00	Program routine service cost (line 9 x line 71)					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00	Per diem capital-related costs (line 75 ÷ line 2)					
77.00	Program capital-related costs (line 9 x line 76)					
78.00	Inpatient routine service cost (line 74 minus line 77)					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00	Inpatient routine service cost per diem limitation					
82.00	Inpatient routine service cost limitation (line 9 x line 81)					
83.00	Reasonable inpatient routine service costs (see instructions)					
84.00	Program inpatient ancillary services (see instructions)					
85.00	Utilization review - physician compensation (see instructions)					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					382
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,069.42
89.00	Observation bed cost (line 87 x line 88) (see instructions)					408,518

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/18/2014 10:51 am	
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	182,091	1,584,876	0.114893	408,518	46,936	90.00
91.00	Nursing School cost	0	1,584,876	0.000000	408,518	0	91.00
92.00	Allied health cost	0	1,584,876	0.000000	408,518	0	92.00
93.00	All other Medical Education	0	1,584,876	0.000000	408,518	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1
		Component CCN: 15M325		Date/Time Prepared: 11/18/2014 10:51 am
		Title XVIII	Subprovider - IPF	PPS
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)		3,477	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,477	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,477	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,931	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		126.36	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		126.36	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,676,682	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,676,682	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)		2,676,682	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)		769.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,256,372	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,256,372	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1	
		Component CCN: 15M325				Date/Time Prepared: 11/18/2014 10:51 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	0	0	0.00	0	0	43.00	
44.00	INTENSIVE CARE UNIT						44.00
45.00	CORONARY CARE UNIT						45.00
46.00	BURN INTENSIVE CARE UNIT						46.00
47.00	SURGICAL INTENSIVE CARE UNIT						47.00
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)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						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						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)						87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325 Component CCN: 15M325		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/18/2014 10:51 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	2,676,682	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,676,682	0.000000	0	0	91.00
92.00	Allied health cost	0	2,676,682	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,676,682	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1
		Title XIX		Date/Time Prepared: 11/18/2014 10:51 am
		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)		2,667	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,482	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)		1,100	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		334	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)		333	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		259	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)		259	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		82	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		126.36	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		126.36	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,363,626	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)		32,727	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)		32,727	25.00
26.00	Total swing-bed cost (see instructions)		778,750	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,584,876	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)		1,584,876	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)		1,069.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		87,692	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)		87,692	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1	
		Title XIX		Hospital		Date/Time Prepared: 11/18/2014 10:51 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,880,195	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,967,887	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)					382	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,069.42	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					408,518	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/18/2014 10:51 am	
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	182,091	1,584,876	0.114893	408,518	46,936	90.00
91.00	Nursing School cost	0	1,584,876	0.000000	408,518	0	91.00
92.00	Allied health cost	0	1,584,876	0.000000	408,518	0	92.00
93.00	All other Medical Education	0	1,584,876	0.000000	408,518	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Prepared: 11/18/2014 10:51 am	
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		485,559	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.643183	22,752	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.151821	1,992	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252620	61,187	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.346811	174,548	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.411866	114,716	65.00
66.00	06600	PHYSICAL THERAPY	0.328585	44,255	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060033	45,400	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.204667	120,670	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.272509	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278024	290,912	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.316226	2,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.495707	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		878,692	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)		878,692	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3	
		Component CCN: 15M325		Date/Time Prepared: 11/18/2014 10:51 am	
		Title XVIII	Subprovider - IPF	PPS	
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
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		3,923,508		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.643183	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.151821	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.252620	88,780	22,428	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.346811	333,374	115,618	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.411866	45,029	18,546	65.00
66.00	06600 PHYSICAL THERAPY	0.328585	82,352	27,060	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.060033	66,886	4,015	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.204667	48,100	9,844	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.272509	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.278024	389,346	108,248	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.316226	94	30	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.495707	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,053,961	305,789	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,053,961		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3	
		Component CCN: 15Z325		Date/Time Prepared: 11/18/2014 10:51 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
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.643183	1,499	964 50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.151821	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252620	19,324	4,882 54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0 56.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.346811	88,733	30,774 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.411866	58,253	23,992 65.00
66.00	06600	PHYSICAL THERAPY	0.328585	295,521	97,104 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.060033	4,026	242 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.204667	86,019	17,605 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.272509	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278024	176,600	49,099 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	0 90.00
91.00	09100	EMERGENCY	0.316226	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.495707	0	0 92.00
200.00		Total (sum of lines 50-94 and 96-98)		729,975	224,662 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		729,975	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Prepared: 11/18/2014 10:51 am	
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		44,521	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.643183	128,472	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.151821	13,446	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252620	977,411	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.346811	531,736	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.411866	71,176	65.00
66.00	06600	PHYSICAL THERAPY	0.328585	83,436	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060033	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.204667	94,810	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.272509	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278024	237,375	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.316226	3,864,535	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.495707	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		6,002,397	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		6,002,397	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/18/2014 10:51 am
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			2,118,616 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			2,118,616 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			2,139,802 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)			14,857 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			957,832 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)			1,167,113 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)			1,167,113 30.00
31.00	Primary payer payments			868 31.00
32.00	Subtotal (line 30 minus line 31)			1,166,245 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)			288,245 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			253,656 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			278,608 36.00
37.00	Subtotal (see instructions)			1,419,901 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00				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)			1,419,901 40.00
40.01	Sequestration adjustment (see instructions)			28,398 40.01
41.00	Interim payments			1,490,607 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-99,104 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: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet E-1
Part I
Date/Time Prepared:
11/18/2014 10:51 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		668,339		1,490,607	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		668,339		1,490,607	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		140,151		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		99,104	6.02	
7.00	Total Medicare program liability (see instructions)		808,490		1,391,503	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151325
Component CCN: 15M325

Period:
From 07/01/2013
To 06/30/2014

Worksheet E-1
Part I
Date/Time Prepared:
11/18/2014 10:51 am
PPS

Title XVIII

Subprovider -
IPF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		2,123,541		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,123,541		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		755		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,124,296		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151325
Component CCN: 15Z325

Period:
From 07/01/2013
To 06/30/2014

Worksheet E-1
Part I
Date/Time Prepared:
11/18/2014 10:51 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		759,802		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		759,802		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		155,458		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		915,260		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 FOR HIT

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet E-1 Part II Date/Time Prepared: 11/18/2014 10:51 am
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			318 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			663 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			178 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			1,100 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			32,526,018 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			845,158 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			388,298 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			382,435 8.00
9.00	Sequestration adjustment amount (see instructions)			7,649 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			374,786 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			402,780 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			-27,994 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet E-2
Component CCN: 15Z325		Date/Time Prepared: 11/18/2014 10:51 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)	720,430	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)	226,909	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	667	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)	947,339	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	947,339	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)	947,339	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	13,400	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)	933,939	0	15.00
16.00		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)	933,939	0	19.00
19.01	Sequestration adjustment (see instructions)	18,679	0	19.01
20.00	Interim payments	759,802	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	155,458	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: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part V Date/Time Prepared: 11/18/2014 10:51 am
		Title XVII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			970,755 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)			970,755 4.00
5.00	Primary payer payments			2,252 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			978,211 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)			978,211 19.00
20.00	Deductibles (exclude professional component)			145,855 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			832,356 22.00
23.00	Coinsurance			8,448 23.00
24.00	Subtotal (line 22 minus line 23)			823,908 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			1,230 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			1,082 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			824,990 28.00
29.00				0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			824,990 30.00
30.01	Sequestration adjustment (see instructions)			16,500 30.01
31.00	Interim payments			668,339 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			140,151 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: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part II Date/Time Prepared: 11/18/2014 10:51 am
		Component CCN: 15M325	Title XVII I	Subprovider - IPF
		PPS		
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		2,324,141	1.00
2.00	Net IPF PPS Outlier Payments		9,970	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		9.526027	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9))) \text{ raised to the power of } .5150 - 1\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		2,334,111	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		2,334,111	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		2,334,111	18.00
19.00	Deductibles		153,440	19.00
20.00	Subtotal (line 18 minus line 19)		2,180,671	20.00
21.00	Coinsurance		13,792	21.00
22.00	Subtotal (line 20 minus line 21)		2,166,879	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		1,184	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		770	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		2,167,649	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00			0	30.00
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		2,167,649	31.00
31.01	Sequestration adjustment (see instructions)		43,353	31.01
32.00	Interim payments		2,123,541	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		755	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		9,970	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151325	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 11/18/2014 10:51 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		1,967,887		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,967,887	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,967,887	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		44,521		8.00
9.00	Ancillary service charges		6,002,397	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		6,046,918	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)		6,046,918	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		4,079,031	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)		1,967,887	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)		1,967,887	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,967,887	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1,967,887	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		1,967,887	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1,967,887	0	40.00
41.00	Interim payments		1,967,887	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0		43.00

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

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet G

Date/Time Prepared:
11/18/2014 10:51 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	311,404	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,294,398	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,878,817	0	0	0	6.00
7.00	Inventory	159,226	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	184,733	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)	3,070,944	0	0	0	11.00
FIXED ASSETS						
12.00	Land	445,242	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	11,597,087	0	0	0	15.00
16.00	Accumulated depreciation	-8,158,431	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	7,786,677	0	0	0	19.00
20.00	Accumulated depreciation	-6,462,835	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,207,740	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	752,403	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	4,393,896	499,849	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,146,299	499,849	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	13,424,983	499,849	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	496,265	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	-896	0	0	0	39.00
40.00	Notes and loans payable (short term)	98,809	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	669,486	0	0	0	43.00
44.00	Other current liabilities	6,703,166	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,966,830	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	4,805,542	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,805,542	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,772,372	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	652,611				52.00
53.00	Specific purpose fund		499,849			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)	652,611	499,849	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,424,983	499,849	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet G-1

Date/Time Prepared:
11/18/2014 10:51 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		-1,360,534		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		729,300				2.00
3.00	Total (sum of line 1 and line 2)		-631,234		0		3.00
4.00	OTHER ADDITIONS	1,962,292		0		0	4.00
5.00	OTHER ADDITIONS	0		499,849		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1,962,292		499,849		10.00
11.00	Subtotal (line 3 plus line 10)		1,331,058		499,849		11.00
12.00	OTHER DEDUCTIONS	678,447		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		678,447		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		652,611		499,849		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	OTHER ADDITIONS		0				4.00
5.00	OTHER ADDITIONS		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	OTHER DEDUCTIONS		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/18/2014 10:51 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,763,669		1,763,669	1.00
2.00	SUBPROVIDER - IPF	4,681,495		4,681,495	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,445,164		6,445,164	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,445,164		6,445,164	17.00
18.00	Ancillary services	4,443,762	12,262,783	16,706,545	18.00
19.00	Outpatient services	0	13,362,446	13,362,446	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NRCC	0	162,802	162,802	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,888,926	25,788,031	36,676,957	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,520,563		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00		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)		14,520,563		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151325

Period:
From 07/01/2013
To 06/30/2014

Worksheet G-3

Date/Time Prepared:
11/18/2014 10:51 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	36,676,957	1.00
2.00	Less contractual allowances and discounts on patients' accounts	22,060,128	2.00
3.00	Net patient revenues (line 1 minus line 2)	14,616,829	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,520,563	4.00
5.00	Net income from service to patients (line 3 minus line 4)	96,266	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	19,080	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	33,328	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	20	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	1,779	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	248	24.00
24.01	EXERCISE REVENUE	21,170	24.01
24.02	HOUSEKEEPING REVENUE	8,040	24.02
24.03	OTHER MAINTENANCE REVENUE	523	24.03
24.04	GRANT REVENUE	6,892	24.04
24.05	INCOME - GENESIS	1,640	24.05
24.06	OTHER OPERATING REVENUE	417,801	24.06
24.07	NET ASSETS RELEASED	1,502	24.07
24.08	HEALTHCARE PLAN FEE REVENUE	121,011	24.08
24.09		0	24.09
25.00	Total other income (sum of lines 6-24)	633,034	25.00
26.00	Total (line 5 plus line 25)	729,300	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	729,300	29.00