

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: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/21/2014 8:58 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/21/2014 Time: 8:58 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST VINCENT SETON SPECIALTY HOSP-LAF (152021) 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	-3,031	0	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	-3,031	0	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. 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: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/19/2014 10:08 am
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	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1501 HARTFORD STREET		PO Box:		Date Certified		Payment System (P, T, O, or N)			
2.00	City: LAFAYETTE		State: IN		Zip Code: 47904		County: TIPPECANOE			
	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX		
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		ST VINCENT SETON SPECIALTY HOSP-LAF		152021	29140	2	02/07/2003	N P O	
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
					From:		To:			
					1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)				07/01/2013		06/30/2014			20.00
21.00	Type of Control (see instructions)						1			21.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				N		N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)									22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				2		N			23.00
					In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days
					1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.				0	0	0	0	0	0
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.				0	0	0	0	0	0
					Urban/Rural 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/19/2014 10:08 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20		
				1.00			
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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		
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>							
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 Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
<u>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.</u>							
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 Site	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
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
<u>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</u>							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					Y	80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00		97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			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)						106.00

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		V	XIX			
		1.00	2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				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.				109.00	
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2			118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	11,447	0		0	118.01
				1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N			121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	15H046		140.00

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1.00		2.00		3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08101		141.00		
142.00	Street: 10330 N. MERIDIAN ST.	PO Box:		Zip Code: 46290		142.00		
143.00	City: INDIANAPOLIS	State: IN		143.00				
							1.00	
144.00	Are provider based physicians' costs included in Worksheet A?						N	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.						Y	145.00
							1.00	
							2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N	146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	157.00		
158.00	SUBPROVIDER					158.00		
159.00	SNF	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00		
161.00	CMHC		N	N	N	161.00		
							1.00	
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	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0.00	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
							1.00	
							2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 11/19/2014 10:08 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)	N			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: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 11/19/2014 10:08 am
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	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			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL		HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3519		JILL.HILL@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 11/19/2014 10:08 am
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		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	10/21/2014	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: 152021

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

Worksheet S-3
Part I
Date/Time Prepared:
11/19/2014 10:08 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	29	10,585	0.00	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)		29	10,585	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		29	10,585	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		29				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: 152021

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

Worksheet S-3
Part I
Date/Time Prepared:
11/19/2014 10:08 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	3,838	336	6,076			1.00
2.00 HMO and other (see instructions)	234	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,838	336	6,076			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)	3,838	336	6,076	0.00	80.39	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	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	80.39	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			24			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: 152021

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

Worksheet S-3
Part I
Date/Time Prepared:
11/19/2014 10:08 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	126	9	188	1.00
2.00 HMO and other (see instructions)				8	0		2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		126	9	188	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 152021

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

Worksheet A

Date/Time Prepared:
11/19/2014 10:08 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT		433,436	433,436	-12	433,424	1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP		359,714	359,714	0	359,714	2.00	
3.00 00300 OTHER CAP REL COSTS		0	0	0	0	3.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	286,529	1,273,538	1,560,067	0	1,560,067	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	759,705	586,955	1,346,660	12	1,346,672	5.00	
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00	
7.00 00700 OPERATION OF PLANT	42,809	96,958	139,767	0	139,767	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	0	46,154	46,154	0	46,154	8.00	
9.00 00900 HOUSEKEEPING	0	4,043	4,043	0	4,043	9.00	
10.00 01000 DIETARY	0	96,988	96,988	0	96,988	10.00	
11.00 01100 CAFETERIA	0	0	0	0	0	11.00	
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00	
13.00 01300 NURSING ADMINISTRATION	338,686	8,524	347,210	0	347,210	13.00	
15.00 01500 PHARMACY	294,971	518,344	813,315	0	813,315	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	18,377	36,776	55,153	0	55,153	16.00	
17.00 01700 SOCIAL SERVICE	28,211	194	28,405	0	28,405	17.00	
18.00 01850 PASTORAL CARE	22,678	0	22,678	0	22,678	18.00	
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00	
20.00 02000 NURSING SCHOOL	0	0	0	0	0	20.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00	
23.00 02300 PARAMED ED PRGM-(SPECFY)	0	0	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	2,109,039	612,783	2,721,822	0	2,721,822	30.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	1,100	157,781	158,881	0	158,881	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	210,086	210,086	0	210,086	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00	
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00	
57.00 05700 CT SCAN	0	42,158	42,158	0	42,158	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	224,558	224,558	0	224,558	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	11,557	11,557	0	11,557	63.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	586,540	462,877	1,049,417	0	1,049,417	65.00	
66.00 06600 PHYSICAL THERAPY	19,558	226,960	246,518	0	246,518	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	41,558	41,558	0	41,558	67.00	
68.00 06800 SPEECH PATHOLOGY	0	67,735	67,735	0	67,735	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	19,242	19,242	0	19,242	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	4,282	4,282	0	4,282	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	110,468	110,468	0	110,468	74.00	
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00	
OTHER REIMBURSABLE COST CENTERS							
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,508,203	5,653,669	10,161,872	0	10,161,872	118.00
NONREIMBURSABLE COST CENTERS							
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00	
194.01 07952 MARKETING	0	0	0	0	0	194.01	
200.00	TOTAL (SUM OF LINES 118-199)	4,508,203	5,653,669	10,161,872	0	10,161,872	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 152021

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

Worksheet A
Date/Time Prepared:
11/19/2014 10:08 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	-104	433,320	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	359,714	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	230,133	1,790,200	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	740,124	2,086,796	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-364	139,403	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	46,154	8.00
9.00	00900	HOUSEKEEPING	0	4,043	9.00
10.00	01000	DIETARY	0	96,988	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-145	347,065	13.00
15.00	01500	PHARMACY	0	813,315	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,175	53,978	16.00
17.00	01700	SOCIAL SERVICE	0	28,405	17.00
18.00	01850	PASTORAL CARE	0	22,678	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,721,822	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	158,881	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	210,086	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	42,158	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	224,558	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	11,557	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,049,417	65.00
66.00	06600	PHYSICAL THERAPY	0	246,518	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	41,558	67.00
68.00	06800	SPEECH PATHOLOGY	0	67,735	68.00
69.00	06900	ELECTROCARDIOLOGY	0	19,242	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,282	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	110,468	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
OTHER REIMBURSABLE COST CENTERS					
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	968,469	11,130,341	118.00
NONREIMBURSABLE COST CENTERS					
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07952	MARKETING	55,819	55,819	194.01
200.00		TOTAL (SUM OF LINES 118-199)	1,024,288	11,186,160	200.00

Provider CCN: 152021

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

Worksheet A-6

Date/Time Prepared:
11/19/2014 10:08 am

		Increases				
Cost Center		Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
A - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12	1.00	
	TOTALS		0	12		
500.00	Grand Total: Increases		0	12	500.00	

RECLASSIFICATIONS

Provider CCN: 152021

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

Worksheet A-6

Date/Time Prepared:
11/19/2014 10:08 am

		Decreases						
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
A - INTEREST								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	12	11		1.00	
	TOTALS		0	12				
500.00	Grand Total: Decreases		0	12			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152021

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

Worksheet A-7
Part I
Date/Time Prepared:
11/19/2014 10:08 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	845,098	74,088	0	74,088	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	1,177,930	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	2,023,028	74,088	0	74,088	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	2,023,028	74,088	0	74,088	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	919,186	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	1,100,445	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	2,019,631	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	2,019,631	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152021

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

Worksheet A-7
Part II
Date/Time Prepared:
11/19/2014 10:08 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	4,782	425,183	116	2,601	754	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	49,757	309,957	0	0	0	2.00
3.00	Total (sum of lines 1-2)	54,539	735,140	116	2,601	754	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	433,436				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	359,714				2.00
3.00	Total (sum of lines 1-2)	0	793,150				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152021

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

Worksheet A-7
Part III
Date/Time Prepared:
11/19/2014 10:08 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	919,186	0	919,186	0.455126	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,100,445	0	1,100,445	0.544874	0	2.00
3.00	Total (sum of lines 1-2)	2,019,631	0	2,019,631	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 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	4,719	425,183	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	49,757	309,957	2.00
3.00	Total (sum of lines 1-2)	0	0	0	54,476	735,140	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 col.s. 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	63	2,601	754	0	433,320	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	359,714	2.00
3.00	Total (sum of lines 1-2)	63	2,601	754	0	793,034	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 152021

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

Worksheet A-8

Date/Time Prepared:
11/19/2014 10:08 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-63	CAP REL COSTS-BLDG & FIXT	1.00		9 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00		0 2.00
3.00 Investment income - other (chapter 2)	B	-7	ADMINISTRATIVE & GENERAL	5.00		0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00		0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00		0 7.00
8.00 Television and radio service (chapter 21)		0		0.00		0 8.00
9.00 Parking lot (chapter 21)		0		0.00		0 9.00
10.00 Provider-based physician adjustment	A-8-2	0				0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,027,431				0 12.00
13.00 Laundry and linen service		0		0.00		0 13.00
14.00 Cafeteria-employees and guests		0		0.00		0 14.00
15.00 Rental of quarters to employee and others		0		0.00		0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0 16.00
17.00 Sale of drugs to other than patients		0		0.00		0 17.00
18.00 Sale of medical records and abstracts	B	-1,175	MEDICAL RECORDS & LIBRARY	16.00		0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00		0 19.00
20.00 Vending machines		0		0.00		0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00		0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00		0 27.00
28.00 Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant		0		0.00		0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00		0 32.00
33.00 MARKETING	A	-500	ADMINISTRATIVE & GENERAL	5.00		0 33.00
33.01 LOBBYING - NALTH	A	-866	ADMINISTRATIVE & GENERAL	5.00		0 33.01

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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
33.02 LOBBYING - OTHER	A	-510	ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03 CHARITY/DONATIONS	A	123	ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.04 CHARITY/DONATIONS	A	-145	NURSING ADMINISTRATION	13.00	0 33.04
33.05		0		0.00	0 33.05
33.06		0		0.00	0 33.06
33.07		0		0.00	0 33.07
33.08		0		0.00	0 33.08
33.09		0		0.00	0 33.09
33.10		0		0.00	0 33.10
33.11		0		0.00	0 33.11
33.12		0		0.00	0 33.12
33.13		0		0.00	0 33.13
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,024,288			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: 152021

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

Worksheet A-8-1

Date/Time Prepared: 11/19/2014 10:08 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS	HOME OFFICE	0	46,202 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,297,007	555,118 2.00
3.00	194.01	MARKETING	HOME OFFICE	55,819	0 3.00
4.00	4.00	EMPLOYEE BENEFITS	SVH CHARGEBACK	22,754	22,754 4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK	90,035	90,035 4.01
4.02	13.00	NURSING ADMINISTRATION	SVH CHARGEBACK	1,200	1,200 4.02
4.03	15.00	PHARMACY	SVH CHARGEBACK	6,564	6,564 4.03
4.04	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACK	5,832	5,832 4.04
4.05	18.00	PASTORAL CARE	SVH CHARGEBACK	25,461	25,461 4.05
4.06	4.00	EMPLOYEE BENEFITS	SELF INSURANCE	847,714	665,782 4.06
4.07	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	63	104 4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	7	12 4.08
4.09	7.00	OPERATION OF PLANT	TRIMEDX	56,087	56,451 4.09
4.10	4.00	EMPLOYEE BENEFITS	PENSION	179,928	85,525 4.10
5.00	0			2,588,471	1,561,040 5.00

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

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

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

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

6.00	G	ST. VINCENT HEA	100.00	ST. VINCENT HEA	100.00	6.00
7.00	G	ASCENSION	100.00	ASCENSION	100.00	7.00
8.00	A	TRIMEDX	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:	HOME OFFICE				100.00

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

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

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

Provider CCN: 152021

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

Worksheet A-8-1

Date/Time Prepared:
11/19/2014 10:08 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	-46,202	0		1.00
2.00	741,889	0		2.00
3.00	55,819	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	181,932	0		4.06
4.07	-41	11		4.07
4.08	-5	0		4.08
4.09	-364	0		4.09
4.10	94,403	0		4.10
5.00	1,027,431			5.00

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

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	HOME OFFICE		7.00
8.00	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.

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152021

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

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Part I
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	433,320	433,320			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	359,714		359,714		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,790,200	0	0	1,790,200	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,086,796	67,764	56,254	322,153	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	139,403	5,805	4,819	18,153	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	46,154	9,568	7,943	0	8.00
9.00 00900	HOUSEKEEPING	4,043	2,867	2,380	0	9.00
10.00 01000	DIETARY	96,988	11,503	9,549	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	347,065	23,544	19,545	143,620	13.00
15.00 01500	PHARMACY	813,315	18,383	15,261	125,082	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	53,978	5,304	4,403	7,793	16.00
17.00 01700	SOCIAL SERVICE	28,405	6,988	5,801	11,963	17.00
18.00 01850	PASTORAL CARE	22,678	0	0	9,617	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,721,822	271,202	225,132	894,337	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	158,881	0	0	466	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	210,086	0	0	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	42,158	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	224,558	5,089	4,224	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 06300	BLOOD STORAGE, PROCESSING & TRANS.	11,557	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	1,049,417	4,157	3,451	248,722	65.00
66.00 06600	PHYSICAL THERAPY	246,518	573	476	8,294	66.00
67.00 06700	OCCUPATIONAL THERAPY	41,558	394	327	0	67.00
68.00 06800	SPEECH PATHOLOGY	67,735	179	149	0	68.00
69.00 06900	ELECTROCARDIOLOGY	19,242	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	4,282	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	110,468	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS						
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,130,341	433,320	359,714	1,790,200	118.00
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07952	MARKETING	55,819	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	11,186,160	433,320	359,714	1,790,200	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152021

Period:
From 07/01/2013
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,532,967				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	49,230	0	217,410		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,636	0	5,782	88,083	8.00
9.00	00900	HOUSEKEEPING	2,719	0	1,733	0	13,742
10.00	01000	DIETARY	34,553	0	6,952	0	455
11.00	01100	CAFETERIA	0	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	156,247	0	14,228	0	932
15.00	01500	PHARMACY	284,537	0	11,110	0	727
16.00	01600	MEDICAL RECORDS & LIBRARY	20,923	0	3,205	0	210
17.00	01700	SOCIAL SERVICE	15,560	0	4,223	0	276
18.00	01850	PASTORAL CARE	9,453	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,203,809	0	163,897	88,083	10,731
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	46,644	0	0	0	0
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	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,497	0	0	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	12,341	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	68,459	0	3,075	0	201
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,383	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	382,220	0	2,512	0	164
66.00	06600	PHYSICAL THERAPY	74,896	0	347	0	23
67.00	06700	OCCUPATIONAL THERAPY	12,376	0	238	0	16
68.00	06800	SPEECH PATHOLOGY	19,923	0	108	0	7
69.00	06900	ELECTROCARDIOLOGY	5,633	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	1,253	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
74.00	07400	RENAL DIALYSIS	32,336	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,516,628	0	217,410	88,083	13,742
NONREIMBURSABLE COST CENTERS							
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07952	MARKETING	16,339	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,532,967	0	217,410	88,083	13,742

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152021

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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	PHARMACY	
		10.00	11.00	12.00	13.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	160,000					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	0	0	705,181		13.00
15.00	01500	0	0	0	0	1,268,415	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	160,000	0	0	553,195	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	256	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	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
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	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	140,743	0	65.00
66.00	06600	0	0	0	10,987	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	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	1,268,415	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	10000	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		160,000	0	0	705,181	1,268,415	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07952	0	0	0	0	0	194.01
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		160,000	0	0	705,181	1,268,415	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152021

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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE		NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
				PASTORAL CARE				
		16.00	17.00	18.00	19.00	20.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	95,816					16.00
17.00	01700	SOCIAL SERVICE	0	73,216				17.00
18.00	01850	PASTORAL CARE	0	0	41,748			18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	39,603	73,216	41,748	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,493	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	1,698	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	519	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	8,068	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	682	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,568	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,808	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,984	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	840	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	611	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	19	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,312	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,611	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS								
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	95,816	73,216	41,748	0	0	118.00
NONREIMBURSABLE COST CENTERS								
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07952	MARKETING	0	0	0	0	0	194.01
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)	95,816	73,216	41,748	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description	INTERNS & RESIDENTS			PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
	21.00	22.00	23.00			
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
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
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE						17.00
18.00 01850 PASTORAL CARE						18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS						19.00
20.00 02000 NURSING SCHOOL						20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0					21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0				22.00
23.00 02300 PARAMED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0	0	6,446,775		30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	209,740	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	273,281	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	55,018	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	313,674	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300 BLOOD STORAGE, PROCESSING & TRANS.	0	0	0	15,622	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	1,851,954	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	344,922	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	56,893	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	88,941	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	25,486	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	5,554	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	1,281,727	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	144,415	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS						
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	0	11,114,002	0	118.00
NONREIMBURSABLE COST CENTERS						
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07952 MARKETING	0	0	0	72,158	0	194.01
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	0	0	11,186,160	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152021

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

Worksheet B
Part I
Date/Time Prepared:
11/19/2014 10:08 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
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
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
18.00	01850 PASTORAL CARE		18.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000 NURSING SCHOOL		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	6,446,775	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	209,740	50.00
51.00	05100 RECOVERY ROOM	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	273,281	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	55.00
56.00	05600 RADIOISOTOPE	0	56.00
57.00	05700 CT SCAN	55,018	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	313,674	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	15,622	63.00
64.00	06400 INTRAVENOUS THERAPY	0	64.00
65.00	06500 RESPIRATORY THERAPY	1,851,954	65.00
66.00	06600 PHYSICAL THERAPY	344,922	66.00
67.00	06700 OCCUPATIONAL THERAPY	56,893	67.00
68.00	06800 SPEECH PATHOLOGY	88,941	68.00
69.00	06900 ELECTROCARDIOLOGY	25,486	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	5,554	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,281,727	73.00
74.00	07400 RENAL DIALYSIS	144,415	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	75.00
OTHER REIMBURSABLE COST CENTERS			
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	100.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,114,002	118.00
NONREIMBURSABLE COST CENTERS			
193.00	19300 NONPAID WORKERS	0	193.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07952 MARKETING	72,158	194.01
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	11,186,160	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

Worksheet B
Part II
Date/Time Prepared:
11/19/2014 10:08 am

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	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	180,199	67,764	56,254	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	5,805	4,819	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	9,568	7,943	8.00
9.00 00900	HOUSEKEEPING	0	2,867	2,380	9.00
10.00 01000	DIETARY	0	11,503	9,549	10.00
11.00 01100	CAFETERIA	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	23,544	19,545	13.00
15.00 01500	PHARMACY	0	18,383	15,261	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	5,304	4,403	16.00
17.00 01700	SOCIAL SERVICE	0	6,988	5,801	17.00
18.00 01850	PASTORAL CARE	0	0	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	271,202	225,132	30.00
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
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
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	5,089	4,224	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
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	4,157	3,451	65.00
66.00 06600	PHYSICAL THERAPY	0	573	476	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	394	327	67.00
68.00 06800	SPEECH PATHOLOGY	0	179	149	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS					
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	180,199	433,320	359,714	118.00
NONREIMBURSABLE COST CENTERS					
193.00 19300	NONPAID WORKERS	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01 07952	MARKETING	0	0	0	194.01
200.00	Cross Foot Adjustments			0	200.00
201.00	Negative Cost Centers		0	0	201.00
202.00	TOTAL (sum lines 118-201)	180,199	433,320	359,714	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

Worksheet B Part II Date/Time Prepared: 11/19/2014 10:08 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	304,217				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	5,913	0	16,537		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,238	0	440	20,189	8.00
9.00	00900	HOUSEKEEPING	327	0	132	0	5,706
10.00	01000	DIETARY	4,150	0	529	0	189
11.00	01100	CAFETERIA	0	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	18,766	0	1,082	0	387
15.00	01500	PHARMACY	34,174	0	845	0	302
16.00	01600	MEDICAL RECORDS & LIBRARY	2,513	0	244	0	87
17.00	01700	SOCIAL SERVICE	1,869	0	321	0	115
18.00	01850	PASTORAL CARE	1,135	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	144,581	0	12,467	20,189	4,456
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,602	0	0	0	0
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	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,386	0	0	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	1,482	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	8,222	0	234	0	84
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	406	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	45,906	0	191	0	68
66.00	06600	PHYSICAL THERAPY	8,995	0	26	0	9
67.00	06700	OCCUPATIONAL THERAPY	1,486	0	18	0	6
68.00	06800	SPEECH PATHOLOGY	2,393	0	8	0	3
69.00	06900	ELECTROCARDIOLOGY	676	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	151	0	0	151	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
74.00	07400	RENAL DIALYSIS	3,884	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	302,255	0	16,537	20,189	5,706
NONREIMBURSABLE COST CENTERS							
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07952	MARKETING	1,962	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	304,217	0	16,537	20,189	5,706

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	PHARMACY	
		10.00	11.00	12.00	13.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	25,920					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	0	0	63,324		13.00
15.00	01500	0	0	0	0	68,965	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	25,920	0	0	49,675	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	23	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	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
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	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	12,639	0	65.00
66.00	06600	0	0	0	987	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	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	68,965	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	10000	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		25,920	0	0	63,324	68,965	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07952	0	0	0	0	0	194.01
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		25,920	0	0	63,324	68,965	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

Worksheet B
Part II
Date/Time Prepared:
11/19/2014 10:08 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
				PASTORAL CARE			
		16.00	17.00	18.00	19.00	20.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,551				16.00
17.00	01700	SOCIAL SERVICE	0	15,094			17.00
18.00	01850	PASTORAL CARE	0	0	1,135		18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,190	15,094	1,135		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	457	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	222	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	68	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	1,057	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	89	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	2,694	0	0		65.00
66.00	06600	PHYSICAL THERAPY	368	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	260	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	110	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	80	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,743	0	0		73.00
74.00	07400	RENAL DIALYSIS	211	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,551	15,094	1,135	0	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07952	MARKETING	0	0	0		194.01
200.00		Cross Foot Adjustments				0	0200.00
201.00		Negative Cost Centers	0	0	0	0	0201.00
202.00		TOTAL (sum lines 118-201)	12,551	15,094	1,135	0	0202.00

ALLOCATION OF CAPITAL RELATED COSTS	Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part II Date/Time Prepared: 11/19/2014 10:08 am
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Cost Center Description	INTERNS & RESIDENTS			PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
	21.00	22.00	23.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
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
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
18.00 01850	PASTORAL CARE					18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		0			22.00
23.00 02300	PARAMED PRGM-(SPECIFY)			0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS				775,041	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM				6,082	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				7,608	0 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC				0	0 55.00
56.00 05600	RADIOISOTOPE				0	0 56.00
57.00 05700	CT SCAN				1,550	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				18,910	0 60.00
60.01 06001	BLOOD LABORATORY				0	0 60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY				0	0 61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS				0	0 62.00
63.00 06300	BLOOD STORAGE, PROCESSING & TRANS.				495	0 63.00
64.00 06400	INTRAVENOUS THERAPY				0	0 64.00
65.00 06500	RESPIRATORY THERAPY				69,106	0 65.00
66.00 06600	PHYSICAL THERAPY				11,434	0 66.00
67.00 06700	OCCUPATIONAL THERAPY				2,491	0 67.00
68.00 06800	SPEECH PATHOLOGY				2,842	0 68.00
69.00 06900	ELECTROCARDIOLOGY				756	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY				153	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS				0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS				70,708	0 73.00
74.00 07400	RENAL DIALYSIS				4,095	0 74.00
75.00 07500	ASC (NON-DISTINCT PART)				0	0 75.00
OTHER REIMBURSABLE COST CENTERS						
100.00 10000	I&R SERVICES-NOT APPRVD PRGM				0	0 100.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	971,271	0 118.00
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS				0	0 193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS				0	0 194.00
194.01 07952	MARKETING				1,962	0 194.01
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	0	0	973,233	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part II Date/Time Prepared: 11/19/2014 10:08 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
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
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
18.00	01850 PASTORAL CARE		18.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000 NURSING SCHOOL		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	775,041	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	6,082	50.00
51.00	05100 RECOVERY ROOM	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,608	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	55.00
56.00	05600 RADIOISOTOPE	0	56.00
57.00	05700 CT SCAN	1,550	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	18,910	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	495	63.00
64.00	06400 INTRAVENOUS THERAPY	0	64.00
65.00	06500 RESPIRATORY THERAPY	69,106	65.00
66.00	06600 PHYSICAL THERAPY	11,434	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,491	67.00
68.00	06800 SPEECH PATHOLOGY	2,842	68.00
69.00	06900 ELECTROCARDIOLOGY	756	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	153	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	70,708	73.00
74.00	07400 RENAL DIALYSIS	4,095	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	75.00
OTHER REIMBURSABLE COST CENTERS			
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	100.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	971,271	118.00
NONREIMBURSABLE COST CENTERS			
193.00	19300 NONPAID WORKERS	0	193.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07952 MARKETING	1,962	194.01
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	973,233	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152021

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

Worksheet B-1

Date/Time Prepared:
11/19/2014 10:08 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	12,092				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		12,092			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	4,221,674		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,891	1,891	759,705	-2,532,967	8,653,193
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	162	162	42,809	0	168,180
8.00 00800	LAUNDRY & LINEN SERVICE	267	267	0	0	63,665
9.00 00900	HOUSEKEEPING	80	80	0	0	9,290
10.00 01000	DIETARY	321	321	0	0	118,040
11.00 01100	CAFETERIA	0	0	0	0	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	657	657	338,686	0	533,774
15.00 01500	PHARMACY	513	513	294,971	0	972,041
16.00 01600	MEDICAL RECORDS & LIBRARY	148	148	18,377	0	71,478
17.00 01700	SOCIAL SERVICE	195	195	28,211	0	53,157
18.00 01850	PASTORAL CARE	0	0	22,678	0	32,295
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,568	7,568	2,109,039	0	4,112,493
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	1,100	0	159,347
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	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	210,086
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00 05600	RADIOISOTOPE	0	0	0	0	0
57.00 05700	CT SCAN	0	0	0	0	42,158
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	142	142	0	0	233,871
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	11,557
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	116	116	586,540	0	1,305,747
66.00 06600	PHYSICAL THERAPY	16	16	19,558	0	255,861
67.00 06700	OCCUPATIONAL THERAPY	11	11	0	0	42,279
68.00 06800	SPEECH PATHOLOGY	5	5	0	0	68,063
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	19,242
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	4,282
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
74.00 07400	RENAL DIALYSIS	0	0	0	0	110,468
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,092	12,092	4,221,674	-2,532,967	8,597,374
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01 07952	MARKETING	0	0	0	0	55,819
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)	433,320	359,714	1,790,200		2,532,967
203.00	Unit cost multiplier (Wkst. B, Part I)	35.835263	29.748098	0.424050		0.292721
204.00	Cost to be allocated (per Wkst. B, Part II)			0		304,217
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.035157

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152021

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

Worksheet B-1

Date/Time Prepared:
11/19/2014 10:08 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	0					6.00
7.00	00700		10,039				7.00
8.00	00800		267	100			8.00
9.00	00900	0	80	0	9,692		9.00
10.00	01000	0	321	0	321	6,076	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	657	0	657	0	13.00
15.00	01500	0	513	0	513	0	15.00
16.00	01600	0	148	0	148	0	16.00
17.00	01700	0	195	0	195	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	7,568	100	7,568	6,076	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	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	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
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	0	142	0	142	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	116	0	116	0	65.00
66.00	06600	0	16	0	16	0	66.00
67.00	06700	0	11	0	11	0	67.00
68.00	06800	0	5	0	5	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	10000	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		0	10,039	100	9,692	6,076	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07952	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		0	217,410	88,083	13,742	160,000	202.00
203.00		0.000000	21.656539	880.830000	1.417870	26.333114	203.00
204.00		0	16,537	20,189	5,706	25,920	204.00
205.00		0.000000	1.647276	201.890000	0.588733	4.265964	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152021

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

Worksheet B-1

Date/Time Prepared:
11/19/2014 10:08 am

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	12.00	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
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	0					11.00
12.00	01200	0	0				12.00
13.00	01300	0	0	104,487			13.00
15.00	01500	0	0	0	1,000		15.00
16.00	01600	0	0	0	0	30,240,020	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	81,967	0	12,501,744	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	38	0	1,102,251	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	0	0	0	0	53.00
54.00	05400	0	0	0	0	535,803	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	163,708	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	0	0	0	0	2,545,827	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	215,162	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	20,854	0	6,490,389	65.00
66.00	06600	0	0	1,628	0	886,132	66.00
67.00	06700	0	0	0	0	625,942	67.00
68.00	06800	0	0	0	0	265,169	68.00
69.00	06900	0	0	0	0	192,727	69.00
70.00	07000	0	0	0	0	5,991	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	1,000	4,200,837	73.00
74.00	07400	0	0	0	0	508,338	74.00
75.00	07500	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	10000	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		0	0	104,487	1,000	30,240,020	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07952	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		0	0	705,181	1,268,415	95,816	202.00
203.00		0.000000	0.000000	6.748983	1,268.415000	0.003169	203.00
204.00		0	0	63,324	68,965	12,551	204.00
205.00		0.000000	0.000000	0.606047	68.965000	0.000415	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152021

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

Worksheet B-1
Date/Time Prepared:
11/19/2014 10:08 am

Cost Center Description	SOCIAL SERVICE (TOTAL PATIENT DAYS)	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	
		PASTORAL CARE (TOTAL PATIENT DAYS)				
		17.00	18.00	19.00	20.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
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
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE	6,076					17.00
18.00 01850 PASTORAL CARE	0	6,076				18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00 02000 NURSING SCHOOL	0	0		0		20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0			0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0				22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	6,076	6,076		0		30.00
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
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS						
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	6,076	6,076	0	0	118.00
NONREIMBURSABLE COST CENTERS						
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07952 MARKETING	0	0	0	0	0	194.01
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)	73,216	41,748	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	12.050033	6.870968	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	15,094	1,135	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.484200	0.186801	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152021

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

Worksheet B-1
Date/Time Prepared:
11/19/2014 10:08 am

Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	22.00	23.00
	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
GENERAL SERVICE COST CENTERS				
1.00 00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00 00500	ADMINISTRATIVE & GENERAL			5.00
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
15.00 01500	PHARMACY			15.00
16.00 01600	MEDICAL RECORDS & LIBRARY			16.00
17.00 01700	SOCIAL SERVICE			17.00
18.00 01850	PASTORAL CARE			18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00 02000	NURSING SCHOOL			20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		22.00
23.00 02300	PARAMED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000	ADULTS & PEDIATRICS		0	30.00
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
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
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
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY			61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
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
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	75.00
OTHER REIMBURSABLE COST CENTERS				
100.00 10000	I&R SERVICES-NOT APPRVD PRGM		0	100.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)		0	118.00
NONREIMBURSABLE COST CENTERS				
193.00 19300	NONPAID WORKERS		0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS		0	194.00
194.01 07952	MARKETING		0	194.01
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)		0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/19/2014 10:08 am
		Title XVIII	Hospital	PPS

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		6,446,775		0	6,446,775 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM		209,740		0	209,740 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		273,281		0	273,281 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC		0		0	0 55.00
56.00 05600	RADIOISOTOPE		0		0	0 56.00
57.00 05700	CT SCAN		55,018		0	55,018 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		313,674		0	313,674 60.00
60.01 06001	BLOOD LABORATORY		0		0	0 60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	0 61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0	0 62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.		15,622		0	15,622 63.00
64.00 06400	INTRAVENOUS THERAPY		0		0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0	1,851,954		0	1,851,954 65.00
66.00 06600	PHYSICAL THERAPY	0	344,922		0	344,922 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	56,893		0	56,893 67.00
68.00 06800	SPEECH PATHOLOGY	0	88,941		0	88,941 68.00
69.00 06900	ELECTROCARDIOLOGY		25,486		0	25,486 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY		5,554		0	5,554 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS		0		0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS		1,281,727		0	1,281,727 73.00
74.00 07400	RENAL DIALYSIS		144,415		0	144,415 74.00
75.00 07500	ASC (NON-DISTINCT PART)		0		0	0 75.00
OTHER REIMBURSABLE COST CENTERS						
100.00 10000	I&R SERVICES-NOT APPRVD PRGM		0		0	0 100.00
200.00	Subtotal (see instructions)		11,114,002	0	0	11,114,002 200.00
201.00	Less Observation Beds		0		0	0 201.00
202.00	Total (see instructions)		11,114,002	0	0	11,114,002 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 152021		Period: From 07/01/2013 To 06/30/2014		Worksheet C Part I Date/Time Prepared: 11/19/2014 10:08 am	
		Title XVIII		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,501,744		12,501,744		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,102,251	0	1,102,251	0.190283	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	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	528,608	7,195	535,803	0.510040	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	162,858	850	163,708	0.336074	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	2,545,563	264	2,545,827	0.123211	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	215,162	0	215,162	0.072606	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	6,381,145	109,244	6,490,389	0.285338	65.00
66.00	06600	PHYSICAL THERAPY	886,132	0	886,132	0.389244	66.00
67.00	06700	OCCUPATIONAL THERAPY	625,942	0	625,942	0.090892	67.00
68.00	06800	SPEECH PATHOLOGY	265,169	0	265,169	0.335413	68.00
69.00	06900	ELECTROCARDIOLOGY	192,233	494	192,727	0.132239	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,991	0	5,991	0.927057	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,200,837	0	4,200,837	0.305112	73.00
74.00	07400	RENAL DIALYSIS	508,338	0	508,338	0.284092	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
200.00		Subtotal (see instructions)	30,121,973	118,047	30,240,020		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	30,121,973	118,047	30,240,020		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/19/2014 10:08 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.190283		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	0.510040		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.336074		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	0.123211		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.072606		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.285338		65.00
66.00	06600 PHYSICAL THERAPY	0.389244		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.090892		67.00
68.00	06800 SPEECH PATHOLOGY	0.335413		68.00
69.00	06900 ELECTROCARDIOLOGY	0.132239		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.927057		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.305112		73.00
74.00	07400 RENAL DIALYSIS	0.284092		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
OTHER REIMBURSABLE COST CENTERS				
100.00	10000 I&R SERVICES-NOT APPRVD PRGM			100.00
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: 152021

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

Worksheet C
Part I
Date/Time Prepared:
11/19/2014 10:08 am

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6,446,775	6,446,775	0	6,446,775	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	209,740	209,740	0	209,740	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	273,281	273,281	0	273,281	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	56.00
57.00	05700 CT SCAN	55,018	55,018	0	55,018	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	313,674	313,674	0	313,674	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	15,622	15,622	0	15,622	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	1,851,954	1,851,954	0	1,851,954	65.00
66.00	06600 PHYSICAL THERAPY	344,922	344,922	0	344,922	66.00
67.00	06700 OCCUPATIONAL THERAPY	56,893	56,893	0	56,893	67.00
68.00	06800 SPEECH PATHOLOGY	88,941	88,941	0	88,941	68.00
69.00	06900 ELECTROCARDIOLOGY	25,486	25,486	0	25,486	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	5,554	5,554	0	5,554	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,281,727	1,281,727	0	1,281,727	73.00
74.00	07400 RENAL DIALYSIS	144,415	144,415	0	144,415	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS						
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
200.00	Subtotal (see instructions)	11,114,002	11,114,002	0	11,114,002	200.00
201.00	Less Observation Beds	0	0	0	0	201.00
202.00	Total (see instructions)	11,114,002	11,114,002	0	11,114,002	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152021

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

Worksheet C
Part I
Date/Time Prepared:
11/19/2014 10:08 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,501,744		12,501,744		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,102,251	0	1,102,251	0.190283	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	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	528,608	7,195	535,803	0.510040	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	162,858	850	163,708	0.336074	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	2,545,563	264	2,545,827	0.123211	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	215,162	0	215,162	0.072606	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	6,381,145	109,244	6,490,389	0.285338	65.00
66.00	06600	PHYSICAL THERAPY	886,132	0	886,132	0.389244	66.00
67.00	06700	OCCUPATIONAL THERAPY	625,942	0	625,942	0.090892	67.00
68.00	06800	SPEECH PATHOLOGY	265,169	0	265,169	0.335413	68.00
69.00	06900	ELECTROCARDIOLOGY	192,233	494	192,727	0.132239	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,991	0	5,991	0.927057	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,200,837	0	4,200,837	0.305112	73.00
74.00	07400	RENAL DIALYSIS	508,338	0	508,338	0.284092	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
200.00		Subtotal (see instructions)	30,121,973	118,047	30,240,020		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	30,121,973	118,047	30,240,020		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/19/2014 10:08 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
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
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	55.00
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
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0.000000	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	75.00
OTHER REIMBURSABLE COST CENTERS			
100.00	10000 I&R SERVICES-NOT APPRVD PRGM		100.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 152021		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part I Date/Time Prepared: 11/19/2014 10:08 am	
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	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	775,041	0	775,041	6,076	127.56	
200.00	Total (Lines 30-199)	775,041		775,041	6,076	200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	3,838	489,575				
200.00	Total (Lines 30-199)	3,838	489,575				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 152021

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

Worksheet D
Part II
Date/Time Prepared:
11/19/2014 10:08 am

Cost Center Description		Title XVIII			Hospital	PPS		
		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	6,082	1,102,251	0.005518	963,602	5,317	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	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,608	535,803	0.014199	320,547	4,551	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	1,550	163,708	0.009468	122,196	1,157	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	18,910	2,545,827	0.007428	1,783,113	13,245	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	495	215,162	0.002301	129,220	297	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	69,106	6,490,389	0.010647	4,634,143	49,340	65.00
66.00	06600	PHYSICAL THERAPY	11,434	886,132	0.012903	503,098	6,491	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,491	625,942	0.003980	371,922	1,480	67.00
68.00	06800	SPEECH PATHOLOGY	2,842	265,169	0.010718	183,297	1,965	68.00
69.00	06900	ELECTROCARDIOLOGY	756	192,727	0.003923	62,845	247	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	153	5,991	0.025538	5,151	132	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,708	4,200,837	0.016832	2,666,232	44,878	73.00
74.00	07400	RENAL DIALYSIS	4,095	508,338	0.008056	265,692	2,140	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
200.00		Total (lines 50-199)	196,230	17,738,276		12,011,058	131,240	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 152021		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part III Date/Time Prepared: 11/19/2014 10:08 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
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	6,076	0.00	3,838	0	0	30.00
200.00		Total (lines 30-199)	6,076		3,838	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/19/2014 10:08 am
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Cost Center Description	Title XVIII				Hospital	PPS	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
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	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
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	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/19/2014 10:08 am
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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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	1,102,251	0.000000	0.000000	963,602	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	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	535,803	0.000000	0.000000	320,547	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	163,708	0.000000	0.000000	122,196	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	2,545,827	0.000000	0.000000	1,783,113	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	215,162	0.000000	0.000000	129,220	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	6,490,389	0.000000	0.000000	4,634,143	65.00
66.00	06600 PHYSICAL THERAPY	0	886,132	0.000000	0.000000	503,098	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	625,942	0.000000	0.000000	371,922	67.00
68.00	06800 SPEECH PATHOLOGY	0	265,169	0.000000	0.000000	183,297	68.00
69.00	06900 ELECTROCARDIOLOGY	0	192,727	0.000000	0.000000	62,845	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	5,991	0.000000	0.000000	5,151	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,200,837	0.000000	0.000000	2,666,232	73.00
74.00	07400 RENAL DIALYSIS	0	508,338	0.000000	0.000000	265,692	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
200.00	Total (lines 50-199)	0	17,738,276			12,011,058	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/19/2014 10:08 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)		
		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	7,195	0		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	850	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	264	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
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	109,244	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	494	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0		75.00
200.00	Total (lines 50-199)	0	118,047	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/19/2014 10:08 am
	Title XVIII	Hospital	PPS

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	0.190283	0	0	0	0 50.00
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.510040	7,195	0	0	3,670 54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0 55.00
56.00 05600 RADIOISOTOPE	0.000000	0	0	0	0 56.00
57.00 05700 CT SCAN	0.336074	850	0	0	286 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00 06000 LABORATORY	0.123211	264	0	0	33 60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0 61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0 62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.072606	0	0	0	0 63.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0 64.00
65.00 06500 RESPIRATORY THERAPY	0.285338	109,244	0	0	31,171 65.00
66.00 06600 PHYSICAL THERAPY	0.389244	0	0	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.090892	0	0	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.335413	0	0	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.132239	494	0	0	65 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.927057	0	0	0	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.305112	0	0	0	0 73.00
74.00 07400 RENAL DIALYSIS	0.284092	0	0	0	0 74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0 75.00
200.00 Subtotal (see instructions)		118,047	0	0	35,225 200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00 Net Charges (line 200 +/- line 201)		118,047	0	0	35,225 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/19/2014 10:08 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
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
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
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: 152021		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part I Date/Time Prepared: 11/19/2014 10:08 am	
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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	775,041	0	775,041	6,076	127.56	
200.00	Total (Lines 30-199)	775,041		775,041	6,076	200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	336	42,860				
200.00	Total (Lines 30-199)	336	42,860				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 152021

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

Worksheet D
Part II
Date/Time Prepared:
11/19/2014 10:08 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	6,082	1,102,251	0.005518	70,883	391	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	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,608	535,803	0.014199	35,754	508	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	1,550	163,708	0.009468	8,500	80	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	18,910	2,545,827	0.007428	158,813	1,180	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	495	215,162	0.002301	13,949	32	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	69,106	6,490,389	0.010647	532,045	5,665	65.00
66.00	06600	PHYSICAL THERAPY	11,434	886,132	0.012903	39,265	507	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,491	625,942	0.003980	31,724	126	67.00
68.00	06800	SPEECH PATHOLOGY	2,842	265,169	0.010718	14,937	160	68.00
69.00	06900	ELECTROCARDIOLOGY	756	192,727	0.003923	8,097	32	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	153	5,991	0.025538	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,708	4,200,837	0.016832	316,323	5,324	73.00
74.00	07400	RENAL DIALYSIS	4,095	508,338	0.008056	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
200.00		Total (lines 50-199)	196,230	17,738,276		1,230,290	14,005	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 152021		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part III Date/Time Prepared: 11/19/2014 10:08 am	
Cost Center Description			Title XIX		Hospital		Cost	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	
200.00		Total (lines 30-199)	0	0	0	0	0	
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	6,076	0.00	336	0	30.00	
200.00		Total (lines 30-199)	6,076		336	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/19/2014 10:08 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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/19/2014 10:08 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	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	1,102,251	0.000000	0.000000	70,883	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	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	535,803	0.000000	0.000000	35,754	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	163,708	0.000000	0.000000	8,500	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	2,545,827	0.000000	0.000000	158,813	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	215,162	0.000000	0.000000	13,949	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,490,389	0.000000	0.000000	532,045	65.00
66.00	06600	PHYSICAL THERAPY	0	886,132	0.000000	0.000000	39,265	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	625,942	0.000000	0.000000	31,724	67.00
68.00	06800	SPEECH PATHOLOGY	0	265,169	0.000000	0.000000	14,937	68.00
69.00	06900	ELECTROCARDIOLOGY	0	192,727	0.000000	0.000000	8,097	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,991	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,200,837	0.000000	0.000000	316,323	73.00
74.00	07400	RENAL DIALYSIS	0	508,338	0.000000	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
200.00		Total (lines 50-199)	0	17,738,276			1,230,290	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/19/2014 10:08 am

Cost Center Description		Title XIX			Hospital	Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
	ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00		
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
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
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
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0		75.00
200.00	Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/19/2014 10:08 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,076	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,076	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)		6,076	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)		3,838	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,446,775	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)		6,446,775	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)		6,446,775	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)		1,061.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,072,195	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)		4,072,195	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/19/2014 10:08 am
Cost Center Description			Title XVIII		Hospital
Intensive Care Type Inpatient Hospital Units			Hospital		PPS
	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
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				3,132,473 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				7,204,668 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)				489,575 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				131,240 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				620,815 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				6,583,853 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)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152021		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/19/2014 10:08 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	775,041	6,446,775	0.120222	0	0	90.00
91.00	Nursing School cost	0	6,446,775	0.000000	0	0	91.00
92.00	Allied health cost	0	6,446,775	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,446,775	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 11/19/2014 10:08 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)		6,076	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,076	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)		6,076	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)		336	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,446,775	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)		6,446,775	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)		6,446,775	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)		1,061.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		356,503	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)		356,503	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152021		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1	
Date/Time Prepared: 11/19/2014 10:08 am		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					327,737		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					684,240		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)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152021		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/19/2014 10:08 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	775,041	6,446,775	0.120222	0	0	90.00
91.00	Nursing School cost	0	6,446,775	0.000000	0	0	91.00
92.00	Allied health cost	0	6,446,775	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,446,775	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Prepared: 11/19/2014 10:08 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		7,156,237		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.190283	963,602	183,357	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	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.510040	320,547	163,492	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.336074	122,196	41,067	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	0.123211	1,783,113	219,699	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.072606	129,220	9,382	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.285338	4,634,143	1,322,297	65.00
66.00	06600 PHYSICAL THERAPY	0.389244	503,098	195,828	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.090892	371,922	33,805	67.00
68.00	06800 SPEECH PATHOLOGY	0.335413	183,297	61,480	68.00
69.00	06900 ELECTROCARDIOLOGY	0.132239	62,845	8,311	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.927057	5,151	4,775	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.305112	2,666,232	813,499	73.00
74.00	07400 RENAL DIALYSIS	0.284092	265,692	75,481	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
200.00	Total (sum of lines 50-94 and 96-98)		12,011,058	3,132,473	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)		12,011,058		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Prepared: 11/19/2014 10:08 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		704,876		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.190283	70,883	13,488	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	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.510040	35,754	18,236	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.336074	8,500	2,857	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	0.123211	158,813	19,568	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.072606	13,949	1,013	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.285338	532,045	151,813	65.00
66.00	06600 PHYSICAL THERAPY	0.389244	39,265	15,284	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.090892	31,724	2,883	67.00
68.00	06800 SPEECH PATHOLOGY	0.335413	14,937	5,010	68.00
69.00	06900 ELECTROCARDIOLOGY	0.132239	8,097	1,071	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.927057	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.305112	316,323	96,514	73.00
74.00	07400 RENAL DIALYSIS	0.284092	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
200.00	Total (sum of lines 50-94 and 96-98)		1,230,290	327,737	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)		1,230,290		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/19/2014 10:08 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			35,225 2.00
3.00	PPS payments			1,723 3.00
4.00	Outlier payment (see instructions)			3,499 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)			0 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)			0 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)			5,222 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			410 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)			4,812 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)			4,812 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			4,812 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)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			4,812 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)			4,812 40.00
40.01	Sequestration adjustment (see instructions)			96 40.01
41.00	Interim payments			4,716 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			0 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: 152021

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

Worksheet E-1
Part I
Date/Time Prepared:
11/19/2014 10:08 am

		Title XVIII		Hospital		PPS	
		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		6,093,523		4,716	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	01/30/2014	49,900		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		49,900		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,143,423		4,716	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		3,031		0	6.02	
7.00	Total Medicare program liability (see instructions)		6,140,392		4,716	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		Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part IV Date/Time Prepared: 11/19/2014 10:08 am
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)			4,746,646 1.00
2.00	Outlier Payments			1,874,535 2.00
3.00	Total PPS Payments (sum of lines 1 and 2)			6,621,181 3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)			0 4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)			0 5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)			0 6.00
7.00	Subtotal (see instructions)			6,621,181 7.00
8.00	Primary payer payments			0 8.00
9.00	Subtotal (line 7 less line 8)			6,621,181 9.00
10.00	Deductibles			16,736 10.00
11.00	Subtotal (line 9 minus line 10)			6,604,445 11.00
12.00	Coinsurance			422,800 12.00
13.00	Subtotal (line 11 minus line 12)			6,181,645 13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			129,325 14.00
15.00	Adjusted reimbursable bad debts (see instructions)			84,061 15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			126,957 16.00
17.00	Subtotal (sum of lines 13 and 15)			6,265,706 17.00
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Other pass through costs (see instructions)			0 19.00
20.00	Outlier payments reconciliation			0 20.00
21.00				0 21.00
21.99	Recovery of Accelerated Depreciation			0 21.99
22.00	Total amount payable to the provider (see instructions)			6,265,706 22.00
22.01	Sequestration adjustment (see instructions)			125,314 22.01
23.00	Interim payments			6,143,423 23.00
24.00	Tentative settlement (for contractor use only)			0 24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)			-3,031 25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions)			0 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 (see instructions)			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152021	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 11/19/2014 10:08 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		684,240		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)		684,240	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)		684,240	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		704,876		8.00
9.00	Ancillary service charges		1,230,290	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,935,166	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1,935,166	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,250,926	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)		684,240	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)		684,240	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)		684,240	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)		684,240	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		684,240	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)		684,240	0	40.00
41.00	Interim payments		684,240	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: 152021

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

Worksheet G

Date/Time Prepared:
11/19/2014 10:08 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	0	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	4,052,693	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,462,040	0	0	0	6.00
7.00	Inventory	141,244	0	0	0	7.00
8.00	Prepaid expenses	32,283	0	0	0	8.00
9.00	Other current assets	11,402,440	15,444	0	0	9.00
10.00	Due from other funds	274,533	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,441,153	15,444	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	919,186	0	0	0	17.00
18.00	Accumulated depreciation	-879,290	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	1,100,445	0	0	0	23.00
24.00	Accumulated depreciation	-918,814	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)	221,527	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	14,662,680	15,444	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	642,367	0	0	0	37.00
38.00	Salaries, wages, and fees payable	316,065	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,648,058	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,606,490	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	3,550	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,550	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,610,040	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	12,052,640				52.00
53.00	Specific purpose fund		15,444			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)	12,052,640	15,444	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	14,662,680	15,444	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 152021

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

Worksheet G-1

Date/Time Prepared:
11/19/2014 10:08 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		10,398,915		104	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,984,432			2.00
3.00	Total (sum of line 1 and line 2)		13,383,347		104	3.00
4.00	DONATIONS	0		15,444		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		15,444	10.00
11.00	Subtotal (line 3 plus line 10)		13,383,347		15,548	11.00
12.00	TRANSFERS TO AFFILIATES	1,330,706		0		12.00
13.00	RELEASED TO OPERATING	0		104		13.00
14.00	ROUNDING	1		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		1,330,707		104	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,052,640		15,444	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	DONATIONS		0			4.00
5.00			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	TRANSFERS TO AFFILIATES		0			12.00
13.00	RELEASED TO OPERATING		0			13.00
14.00	ROUNDING		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: 152021

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/19/2014 10:08 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	12,501,744		12,501,744	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,501,744		12,501,744	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	12,501,744		12,501,744	17.00
18.00	Ancillary services	17,620,229	118,047	17,738,276	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	30,121,973	118,047	30,240,020	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		10,161,872		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)		10,161,872		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 152021

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

Worksheet G-3

Date/Time Prepared:
11/19/2014 10:08 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	30,240,020	1.00
2.00	Less contractual allowances and discounts on patients' accounts	18,310,753	2.00
3.00	Net patient revenues (line 1 minus line 2)	11,929,267	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	10,161,872	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,767,395	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	449,872	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	1,175	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	ASSETS RELEASED FROM RESTRICTIONS	104	24.00
24.01	UNREALIZED GAIN	765,886	24.01
24.02		0	24.02
24.03		0	24.03
25.00	Total other income (sum of lines 6-24)	1,217,037	25.00
26.00	Total (line 5 plus line 25)	2,984,432	26.00
27.00		0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,984,432	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

Provider CCN: 152021

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

Worksheet I-5

Date/Time Prepared:
11/19/2014 10:08 am

		1.00	2.00	
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B				
1.00	Total expenses related to care of program beneficiaries (see instructions)		0	1.00
2.00	Total payment due (from Wkst. 1-4, col. 6, line 11) (see instructions)			2.00
2.01	Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)	0	0	2.01
2.02	Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)	0	0	2.02
2.03	Total payment due (see instructions)	0	0	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)			3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients			4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012	0	0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	0	0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	0	0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Total bad debts (sum of line 5 through line 5.04)	0	0	5.05
6.00	Allowable bad debts (see instructions)	0		6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	8.00
9.00	Program payment (see instructions)	0	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				
12.00	Total allowable expenses (see instructions)		0	12.00
13.00	Total composite costs (from Wkst. 1-4, col. 2, line 11)		0	13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)		0.000000	14.00