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: 151316	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/25/2014 11:34 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/25/2014 Time: 11:34 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT FRANKFORT HOSPITAL (151316) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-58,780	-228,975	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-43,309	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-102,089	-228,975	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: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/25/2014 10:27 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1300 SOUTH JACKSON STREET	PO Box:			1.00
2.00	City: FRANKFORT	State: IN	Zip Code: 46041	County: CLINTON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. VINCENT FRANKFORT HOSPITAL	151316	99915	1	01/21/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT FRANKFORT HOSPITAL	15Z316	99915		01/21/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2014 10:27 am

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/25/2014 10:27 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2014 10:27 am

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			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.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2014 10:27 am

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	800	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151316	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/25/2014 10:27 am

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 10330 N. MERIDIAN ST. SUITE 420	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 11/25/2014 10:27 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: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/25/2014 10:27 am

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3519	JILL.HILL@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/25/2014 10:27 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	10/21/2014			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: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 11/25/2014 10:27 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	58,128.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	58,128.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	58,128.00	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)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/25/2014 10:27 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,323	144	2,422			1.00
2.00	HMO and other (see instructions)	139	357				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	812	0	812			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		19	155			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,135	163	3,389			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		369	462			13.00
14.00	Total (see instructions)	2,135	532	3,851	0.00	133.00	14.00
15.00	CAH visits	10,478	2,268	35,193			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	133.00	27.00
28.00	Observation Bed Days		0	419			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			14			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	3	57			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: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 11/25/2014 10:27 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	330	46	837	1.00
2.00	HMO and other (see instructions)			34	149		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	330	46	837	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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-10 | Date/Time Prepared: 11/25/2014 10:27 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.317221	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,683,469	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,942,335	5.00
6.00	Medicaid charges	13,117,529	6.00
7.00	Medicaid cost (line 1 times line 6)	4,161,156	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	390	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	4,838,255	37,052	4,875,307	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,534,796	11,754	1,546,550	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,534,796	11,754	1,546,550	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,445,773	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	400,604	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,045,169	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	648,771	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,195,321	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,195,321	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/25/2014 10:27 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,861,974	1,861,974	-1,575	1,860,399	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		774,808	774,808	0	774,808	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	215,560	2,127,531	2,343,091	-480	2,342,611	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,847,298	3,191,075	5,038,373	1,119	5,039,492	5.00
7.00	00700	OPERATION OF PLANT	219,638	1,316,201	1,535,839	-2,008	1,533,831	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	92,152	92,152	0	92,152	8.00
9.00	00900	HOUSEKEEPING	0	426,329	426,329	0	426,329	9.00
10.00	01000	DIETARY	0	556,318	556,318	-462,282	94,036	10.00
11.00	01100	CAFETERIA	0	0	0	462,072	462,072	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	762,862	23,035	785,897	-6	785,891	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	122,584	5,462	128,046	-3,185	124,861	14.00
15.00	01500	PHARMACY	258,249	337,009	595,258	-662	594,596	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	68,988	79,037	148,025	-6	148,019	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,576,945	361,346	1,938,291	-732,419	1,205,872	30.00
43.00	04300	NURSERY	0	0	0	159,849	159,849	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	515,147	546,558	1,061,705	-66,325	995,380	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	542,554	542,554	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	585,854	315,096	900,950	-4,474	896,476	54.00
60.00	06000	LABORATORY	476,505	753,390	1,229,895	-5,973	1,223,922	60.00
65.00	06500	RESPIRATORY THERAPY	151,283	109,027	260,310	-2,896	257,414	65.00
66.00	06600	PHYSICAL THERAPY	0	828,737	828,737	-183,885	644,852	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	178,904	178,904	67.00
68.00	06800	SPEECH PATHOLOGY	73,457	1,318	74,775	0	74,775	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48,857	48,857	148,307	197,164	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	53,003	53,003	0	53,003	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	903,221	941,803	1,845,024	-26,325	1,818,699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,777,591	14,750,066	22,527,657	304	22,527,961	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	8,051	-17,925	-9,874	-304	-10,178	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	1,483	1,483	0	1,483	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	371	371	0	371	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	7,785,642	14,733,995	22,519,637	0	22,519,637	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/25/2014 10:27 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	-14,278	1,846,121		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	774,808		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	123,565	2,466,176		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-277,405	4,762,087		5.00
7.00	00700	OPERATION OF PLANT	-2,948	1,530,883		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	92,152		8.00
9.00	00900	HOUSEKEEPING	0	426,329		9.00
10.00	01000	DIETARY	0	94,036		10.00
11.00	01100	CAFETERIA	-113,653	348,419		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	-2,915	782,976		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-12,611	112,250		14.00
15.00	01500	PHARMACY	-11,095	583,501		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	148,019		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-95,611	1,110,261		30.00
43.00	04300	NURSERY	0	159,849		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-73,474	921,906		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	542,554		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-146,178	750,298		54.00
60.00	06000	LABORATORY	0	1,223,922		60.00
65.00	06500	RESPIRATORY THERAPY	0	257,414		65.00
66.00	06600	PHYSICAL THERAPY	-15,657	629,195		66.00
67.00	06700	OCCUPATIONAL THERAPY	-646	178,258		67.00
68.00	06800	SPEECH PATHOLOGY	0	74,775		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	197,164		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	53,003		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	1,818,699		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-642,906	21,885,055		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	-10,178		194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	1,483		194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	155,345	155,716		194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-487,561	22,032,076		200.00

RECLASSIFICATIONS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/25/2014 10:27 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	0	462,072	1.00
	TOTALS		0	462,072	
	B - NURSEY AND L&D RECLASS				
1.00	NURSERY	43.00	121,972	40,316	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	413,989	136,840	2.00
	TOTALS		535,961	177,156	
	C - INTEREST				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,575	1.00
	TOTALS		0	1,575	
	D - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	148,307	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	TOTALS		0	148,307	
	E - OT EXPENSE				
1.00	OCCUPATIONAL THERAPY	67.00	0	178,904	1.00
	TOTALS		0	178,904	
500.00	Grand Total: Increases		535,961	968,014	500.00

RECLASSIFICATIONS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/25/2014 10:27 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	0	462,072	0		1.00
	TOTALS		0	462,072			
	B - NURSEY AND L&D RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	535,961	177,156	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		535,961	177,156			
	C - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,575	9		1.00
	TOTALS		0	1,575			
	D - MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	480	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	456	0		2.00
3.00	OPERATION OF PLANT	7.00	0	2,008	0		3.00
4.00	DIETARY	10.00	0	210	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	6	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,185	0		6.00
7.00	PHARMACY	15.00	0	662	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	6	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	19,302	0		9.00
10.00	OPERATING ROOM	50.00	0	66,325	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,474	0		11.00
12.00	LABORATORY	60.00	0	5,973	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	2,896	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	4,981	0		14.00
15.00	EMERGENCY	91.00	0	26,325	0		15.00
16.00	OTHER NONREIMBURSABLE - CLINIC	194.00	0	304	0		16.00
17.00	NURSERY	43.00	0	2,439	0		17.00
18.00	DELIVERY ROOM & LABOR ROOM	52.00	0	8,275	0		18.00
	TOTALS		0	148,307			
	E - OT EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	178,904	0		1.00
	TOTALS		0	178,904			
500.00	Grand Total: Decreases		535,961	968,014			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 11/25/2014 10:27 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	160,146	0	0	0	0	1.00
2.00	Land Improvements	66,241	0	0	0	0	2.00
3.00	Buildings and Fixtures	1,281,956	0	0	0	0	3.00
4.00	Building Improvements	624,453	0	0	0	0	4.00
5.00	Fixed Equipment	758,364	0	0	0	18,037	5.00
6.00	Movable Equipment	6,144,862	0	0	0	804,786	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	9,036,022	0	0	0	822,823	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	9,036,022	0	0	0	822,823	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	160,146	0	1.00
2.00	Land Improvements	66,241	0	2.00
3.00	Buildings and Fixtures	1,281,956	0	3.00
4.00	Building Improvements	624,453	0	4.00
5.00	Fixed Equipment	740,327	0	5.00
6.00	Movable Equipment	5,340,076	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,213,199	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	8,213,199	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 11/25/2014 10:27 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	132,306	1,672,750	15,853	18,389	22,676	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	286,268	486,925	0	1,615	0	2.00
3.00	Total (sum of lines 1-2)	418,574	2,159,675	15,853	20,004	22,676	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,861,974	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	774,808	2.00
3.00	Total (sum of lines 1-2)	0	2,636,782	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 11/25/2014 10:27 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,873,123	0	2,873,123	0.349818	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,340,076	0	5,340,076	0.650182	0	2.00
3.00	Total (sum of lines 1-2)	8,213,199	0	8,213,199	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	130,731	1,672,750	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	286,268	486,925	2.00
3.00	Total (sum of lines 1-2)	0	0	0	416,999	2,159,675	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,575	18,389	22,676	0	1,846,121	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,615	0	0	774,808	2.00
3.00	Total (sum of lines 1-2)	1,575	20,004	22,676	0	2,620,929	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/25/2014 10:27 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-8,642	CAP REL COSTS-BLDG & FIXT	1.00	11	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	-953	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)	A	-3,186	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-6,465	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-315,263			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	1,183,434			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-113,653	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-11,095	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-8,810	ADMINISTRATIVE & GENERAL	5.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	-646	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	MISC INCOME	B	-12,611	CENTRAL SERVICES & SUPPLY	14.00	0	33.00
33.01	MISC INCOME	B	-200	PHYSICAL THERAPY	66.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/25/2014 10:27 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	MISC INCOME	B	-2,915	NURSING ADMINISTRATION	13.00	0	33.02
33.03			0		0.00	0	33.03
33.04			0		0.00	0	33.04
33.05	DONATION EXPENSE	A	-1,969	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ATHLETIC TRAINER	A	-15,457	PHYSICAL THERAPY	66.00	0	33.06
33.07	PROVIDER TAX ADJ	A	-1,168,414	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	LOBBYING	A	-716	ADMINISTRATIVE & GENERAL	5.00	0	33.08
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-487,561				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: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-1 | Date/Time Prepared: 11/25/2014 10:27 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	0	130,626	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,483,217	1,569,487	2.00
3.00	194.02	OTHER NONREIMBURSABLE - MARK	HOME OFFICE	155,345	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	370,730	370,730	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACKS	1,589,356	1,589,356	4.01
4.02	9.00	HOUSEKEEPING	SVH CHARGEBACKS	-78,914	-78,914	4.02
4.03	14.00	CENTRAL SERVICES & SUPPLY	SVH CHARGEBACKS	96,806	96,806	4.03
4.04	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACKS	147,420	147,420	4.04
4.05	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACKS	5,664	5,664	4.05
4.06	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	23,520	23,520	4.06
4.07	65.00	RESPIRATORY THERAPY	SVH CHARGEBACKS	93,960	93,960	4.07
4.08	194.00	OTHER NONREIMBURSABLE - CLIN	SVH CHARGEBACKS	-1,920	-1,920	4.08
4.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE SELF INSURANCE	905,142	848,444	4.09
4.10	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	8,642	14,278	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	953	1,575	4.11
4.12	7.00	OPERATION OF PLANT	TRIMEDX	454,066	457,014	4.12
4.13	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	260,294	62,801	4.13
4.14	0.00			0	0	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	0.00			0	0	4.18
4.19	0.00			0	0	4.19
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,514,281	5,330,847	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	G		0.00	ST. VINCENT HEA	100.00	6.00
7.00	B		0.00	ST. VINCENT HOS	100.00	7.00
8.00	G		0.00	ASCENSION	100.00	8.00
9.00	A		0.00	TRIMEDX	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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.

(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: 151316	Period: From 07/01/2013 To 06/30/2014	Worksheet A-8-1 Date/Time Prepared: 11/25/2014 10:27 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	-130,626	0		1.00
2.00	913,730	0		2.00
3.00	155,345	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	56,698	0		4.09
4.10	-5,636	11		4.10
4.11	-622	0		4.11
4.12	-2,948	0		4.12
4.13	197,493	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
5.00	1,183,434			5.00

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

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

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

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

6.00	ADMINISTRATION		6.00
7.00	HOSPITAL		7.00
8.00	ADMINISTRATION		8.00
9.00	TECHNOLOGY MGMT		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 11/25/2014 10:27 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	95,611	95,611	0	0	0	1.00
2.00	50.00	OPERATING ROOM	132,994	73,474	59,520	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	146,178	146,178	0	0	0	3.00
4.00	60.00	LABORATORY	50,421	0	50,421	0	0	4.00
5.00	91.00	EMERGENCY	643,347	0	643,347	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,068,551	315,263	753,288		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	95,611		1.00
2.00	50.00	OPERATING ROOM	0	0	0	73,474		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	146,178		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	91.00	EMERGENCY	0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	315,263		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2014 10:27 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					347	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.21	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	6,408.00	1,266.00	2,842.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.05	57.79	38.53	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.53	38.53	28.90			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					493,736	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					73,162	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					566,898	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					109,502	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					676,400	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					676,400	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					13,370	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					13,370	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,808	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					15,178	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					15,178	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151316	Period: From 07/01/2013 To 06/30/2014	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2014 10:27 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.05	57.79	38.53	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	676,400		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	15,178		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	691,578		63.00
64.00	Total cost of outside supplier services (from your records)	621,061		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	13,370		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,808		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	15,178		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,808		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,808		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2014 10:27 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		246	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.21	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,004.00	233.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.04	54.78	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.52	36.52	27.39			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	146,372	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	12,764	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	159,136	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	159,136	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	159,136	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	8,984	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	8,984	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,282	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	10,266	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	10,266	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151316	Period: From 07/01/2013 To 06/30/2014	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2014 10:27 am
		Occupational Therapy	Cost

						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.04	54.78	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	159,136		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	10,266		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	169,402		63.00
64.00	Total cost of outside supplier services (from your records)	170,048		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	646		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	8,984		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,282		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	10,266		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,282		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,282		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/25/2014 10:27 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,846,121	1,846,121				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	774,808		774,808			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,466,176	19,101	10,868	2,496,145		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,762,087	172,558	98,183	609,123	5,641,951	5.00
7.00	00700	OPERATION OF PLANT	1,530,883	189,699	107,936	72,423	1,900,941	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	92,152	14,407	8,197	0	114,756	8.00
9.00	00900	HOUSEKEEPING	426,329	33,520	19,072	0	478,921	9.00
10.00	01000	DIETARY	94,036	45,620	25,957	0	165,613	10.00
11.00	01100	CAFETERIA	348,419	21,454	12,207	0	382,080	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	782,976	42,574	24,224	251,545	1,101,319	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	112,250	61,710	35,112	40,421	249,493	14.00
15.00	01500	PHARMACY	583,501	31,778	18,081	85,155	718,515	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	148,019	35,988	20,477	22,748	227,232	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,110,261	286,036	162,753	343,252	1,902,302	30.00
43.00	04300	NURSERY	159,849	5,756	3,275	40,219	209,099	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	921,906	120,883	68,781	169,864	1,281,434	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	542,554	25,203	14,340	136,508	718,605	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	750,298	84,514	48,088	193,178	1,076,078	54.00
60.00	06000	LABORATORY	1,223,922	35,930	20,444	157,122	1,437,418	60.00
65.00	06500	RESPIRATORY THERAPY	257,414	17,786	10,120	49,884	335,204	65.00
66.00	06600	PHYSICAL THERAPY	629,195	35,746	20,339	0	685,280	66.00
67.00	06700	OCCUPATIONAL THERAPY	178,258	2,157	1,227	0	181,642	67.00
68.00	06800	SPEECH PATHOLOGY	74,775	6,679	3,800	24,222	109,476	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	197,164	0	0	0	197,164	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	53,003	0	0	0	53,003	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,818,699	59,496	33,852	297,826	2,209,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,885,055	1,348,595	767,333	2,493,490	21,377,399	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,252	3,557	0	9,809	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	-10,178	0	0	2,655	-7,523	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	1,483	6,886	3,918	0	12,287	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	155,716	0	0	0	155,716	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	484,388	0	0	484,388	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	22,032,076	1,846,121	774,808	2,496,145	22,032,076	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/25/2014 10:27 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,641,951					5.00
7.00	00700	OPERATION OF PLANT	654,059	2,555,000				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	39,484	25,130	179,370			8.00
9.00	00900	HOUSEKEEPING	164,783	58,469	0	702,173		9.00
10.00	01000	DIETARY	56,983	79,575	5,377	33,449	340,997	10.00
11.00	01100	CAFETERIA	131,463	37,423	0	15,731	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	378,932	74,263	0	31,217	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	85,843	107,642	1,788	45,247	0	14.00
15.00	01500	PHARMACY	247,220	55,431	0	23,300	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	78,184	62,774	0	26,387	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	654,527	498,936	64,575	209,728	340,997	30.00
43.00	04300	NURSERY	71,945	10,040	0	4,220	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	440,904	210,858	16,144	88,634	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	247,251	43,962	0	18,480	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	370,247	147,419	0	61,968	0	54.00
60.00	06000	LABORATORY	494,574	62,674	0	26,345	0	60.00
65.00	06500	RESPIRATORY THERAPY	115,334	31,025	0	13,041	0	65.00
66.00	06600	PHYSICAL THERAPY	235,785	62,352	32,183	26,210	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,498	3,762	9,070	1,582	0	67.00
68.00	06800	SPEECH PATHOLOGY	37,668	11,649	0	4,897	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	67,838	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,237	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	760,348	103,779	26,911	43,624	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,414,107	1,687,163	156,048	674,060	340,997	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,375	10,905	0	4,584	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	23,322	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	4,228	12,012	0	5,049	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	53,577	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	166,664	844,920	0	18,480	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,641,951	2,555,000	179,370	702,173	340,997	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/25/2014 10:27 am

		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	566,697					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	66,048	0	1,651,779			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,986	0	0	505,999		14.00
15.00	01500	PHARMACY	21,323	0	0	2,001	1,067,790	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,966	0	0	18	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	121,376	0	441,238	58,331	0	30.00
43.00	04300	NURSERY	11,524	0	41,891	7,369	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	47,154	0	171,418	200,435	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,110	0	142,177	25,008	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	56,591	0	205,723	13,520	0	54.00
60.00	06000	LABORATORY	55,962	0	203,440	18,051	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,649	0	49,618	8,751	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,053	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,698	0	20,713	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	37,368	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	40,540	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,067,790	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	103,310	0	375,561	79,554	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	566,697	0	1,651,779	505,999	1,067,790	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	566,697	0	1,651,779	505,999	1,067,790	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/25/2014 10:27 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	403,561					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,017	4,320,027	0	4,320,027		30.00
43.00	04300	NURSERY	4,247	360,335	0	360,335		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	55,940	2,512,921	0	2,512,921		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,414	1,249,007	0	1,249,007		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	97,193	2,028,739	0	2,028,739		54.00
60.00	06000	LABORATORY	75,065	2,373,529	0	2,373,529		60.00
65.00	06500	RESPIRATORY THERAPY	10,157	576,779	0	576,779		65.00
66.00	06600	PHYSICAL THERAPY	29,700	1,086,563	0	1,086,563		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,487	262,041	0	262,041		67.00
68.00	06800	SPEECH PATHOLOGY	1,127	191,228	0	191,228		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	302,370	0	302,370		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	111,780	0	111,780		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,067,790	0	1,067,790		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	84,214	3,787,174	0	3,787,174		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	403,561	20,230,283	0	20,230,283		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28,673	0	28,673		190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	15,799	0	15,799		194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	33,576	0	33,576		194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	209,293	0	209,293		194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	1,514,452	0	1,514,452		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	403,561	22,032,076	0	22,032,076		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/25/2014 10:27 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	19,101	10,868	29,969	29,969	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	353,600	172,558	98,183	624,341	7,314	5.00
7.00	00700	OPERATION OF PLANT	0	189,699	107,936	297,635	870	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,407	8,197	22,604	0	8.00
9.00	00900	HOUSEKEEPING	0	33,520	19,072	52,592	0	9.00
10.00	01000	DIETARY	0	45,620	25,957	71,577	0	10.00
11.00	01100	CAFETERIA	0	21,454	12,207	33,661	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	42,574	24,224	66,798	3,020	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	61,710	35,112	96,822	485	14.00
15.00	01500	PHARMACY	0	31,778	18,081	49,859	1,022	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,988	20,477	56,465	273	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	286,036	162,753	448,789	4,121	30.00
43.00	04300	NURSERY	0	5,756	3,275	9,031	483	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	120,883	68,781	189,664	2,039	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	25,203	14,340	39,543	1,639	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84,514	48,088	132,602	2,319	54.00
60.00	06000	LABORATORY	0	35,930	20,444	56,374	1,886	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,786	10,120	27,906	599	65.00
66.00	06600	PHYSICAL THERAPY	0	35,746	20,339	56,085	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,157	1,227	3,384	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,679	3,800	10,479	291	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	59,496	33,852	93,348	3,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	353,600	1,348,595	767,333	2,469,528	29,937	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,252	3,557	9,809	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	32	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	6,886	3,918	10,804	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	484,388	0	484,388	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	353,600	1,846,121	774,808	2,974,529	29,969	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 11/25/2014 10:27 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	631,655					5.00
7.00	00700	OPERATION OF PLANT	73,226	371,731				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,421	3,656	30,681			8.00
9.00	00900	HOUSEKEEPING	18,449	8,507	0	79,548		9.00
10.00	01000	DIETARY	6,380	11,577	920	3,789	94,243	10.00
11.00	01100	CAFETERIA	14,718	5,445	0	1,782	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	42,424	10,805	0	3,536	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,611	15,661	306	5,126	0	14.00
15.00	01500	PHARMACY	27,678	8,065	0	2,640	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,753	9,133	0	2,989	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	73,279	72,591	11,046	23,761	94,243	30.00
43.00	04300	NURSERY	8,055	1,461	0	478	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,362	30,678	2,761	10,041	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,681	6,396	0	2,094	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,452	21,448	0	7,020	0	54.00
60.00	06000	LABORATORY	55,371	9,119	0	2,985	0	60.00
65.00	06500	RESPIRATORY THERAPY	12,912	4,514	0	1,477	0	65.00
66.00	06600	PHYSICAL THERAPY	26,398	9,072	5,505	2,969	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,997	547	1,551	179	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,217	1,695	0	555	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,595	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,042	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	85,126	15,099	4,603	4,942	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	606,147	245,469	26,692	76,363	94,243	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	378	1,587	0	519	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	3,989	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	473	1,748	0	572	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	5,998	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	18,659	122,927	0	2,094	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	631,655	371,731	30,681	79,548	94,243	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/25/2014 10:27 am

		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	55,606					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	6,481	0	133,064			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,569	0	0	129,580		14.00
15.00	01500	PHARMACY	2,092	0	0	512	91,868	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	880	0	0	5	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,909	0	35,544	14,938	0	30.00
43.00	04300	NURSERY	1,131	0	3,375	1,887	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,627	0	13,809	51,328	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,838	0	11,454	6,404	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,553	0	16,573	3,462	0	54.00
60.00	06000	LABORATORY	5,491	0	16,389	4,623	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,339	0	3,997	2,241	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,855	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	559	0	1,669	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,570	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,382	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	91,868	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,137	0	30,254	20,373	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,606	0	133,064	129,580	91,868	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	55,606	0	133,064	129,580	91,868	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/25/2014 10:27 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	78,498					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,449	795,670	0	795,670		30.00
43.00	04300	NURSERY	826	26,727	0	26,727		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,881	365,190	0	365,190		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,804	101,853	0	101,853		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,908	249,337	0	249,337		54.00
60.00	06000	LABORATORY	14,600	166,838	0	166,838		60.00
65.00	06500	RESPIRATORY THERAPY	1,976	56,961	0	56,961		65.00
66.00	06600	PHYSICAL THERAPY	5,777	109,661	0	109,661		66.00
67.00	06700	OCCUPATIONAL THERAPY	678	13,336	0	13,336		67.00
68.00	06800	SPEECH PATHOLOGY	219	19,684	0	19,684		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,165	0	17,165		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,424	0	12,424		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	91,868	0	91,868		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	16,380	283,838	0	283,838		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	78,498	2,310,552	0	2,310,552		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,293	0	12,293		190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	4,021	0	4,021		194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	13,597	0	13,597		194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	5,998	0	5,998		194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	628,068	0	628,068		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	78,498	2,974,529	0	2,974,529		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/25/2014 10:27 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	160,050					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		118,056				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,656	1,656	7,570,082			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,960	14,960	1,847,298	-5,641,951	16,397,648	5.00
7.00	00700	OPERATION OF PLANT	16,446	16,446	219,638	0	1,900,941	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,249	1,249	0	0	114,756	8.00
9.00	00900	HOUSEKEEPING	2,906	2,906	0	0	478,921	9.00
10.00	01000	DIETARY	3,955	3,955	0	0	165,613	10.00
11.00	01100	CAFETERIA	1,860	1,860	0	0	382,080	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,691	3,691	762,862	0	1,101,319	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,350	5,350	122,584	0	249,493	14.00
15.00	01500	PHARMACY	2,755	2,755	258,249	0	718,515	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,120	3,120	68,988	0	227,232	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,798	24,798	1,040,984	0	1,902,302	30.00
43.00	04300	NURSERY	499	499	121,972	0	209,099	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,480	10,480	515,147	0	1,281,434	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,185	2,185	413,989	0	718,605	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,327	7,327	585,854	0	1,076,078	54.00
60.00	06000	LABORATORY	3,115	3,115	476,505	0	1,437,418	60.00
65.00	06500	RESPIRATORY THERAPY	1,542	1,542	151,283	0	335,204	65.00
66.00	06600	PHYSICAL THERAPY	3,099	3,099	0	0	685,280	66.00
67.00	06700	OCCUPATIONAL THERAPY	187	187	0	0	181,642	67.00
68.00	06800	SPEECH PATHOLOGY	579	579	73,457	0	109,476	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	197,164	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	53,003	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,158	5,158	903,221	0	2,209,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	116,917	116,917	7,562,031	-5,641,951	15,735,448	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	542	542	0	0	9,809	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	8,051	7,523	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	597	597	0	0	12,287	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	155,716	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	41,994	0	0	0	484,388	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,846,121	774,808	2,496,145		5,641,951	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.534652	6.563055	0.329738		0.344071	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			29,969		631,655	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003959		0.038521	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/25/2014 10:27 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	126,988					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,249	13,744				8.00
9.00	00900	HOUSEKEEPING	2,906	0	83,024			9.00
10.00	01000	DIETARY	3,955	412	3,955	12,774		10.00
11.00	01100	CAFETERIA	1,860	0	1,860	0	190,366	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,691	0	3,691	0	22,187	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,350	137	5,350	0	5,370	14.00
15.00	01500	PHARMACY	2,755	0	2,755	0	7,163	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,120	0	3,120	0	3,012	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,798	4,948	24,798	12,774	40,773	30.00
43.00	04300	NURSERY	499	0	499	0	3,871	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,480	1,237	10,480	0	15,840	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,185	0	2,185	0	13,138	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,327	0	7,327	0	19,010	54.00
60.00	06000	LABORATORY	3,115	0	3,115	0	18,799	60.00
65.00	06500	RESPIRATORY THERAPY	1,542	0	1,542	0	4,585	65.00
66.00	06600	PHYSICAL THERAPY	3,099	2,466	3,099	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	187	695	187	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	579	0	579	0	1,914	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,158	2,062	5,158	0	34,704	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	83,855	11,957	79,700	12,774	190,366	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	542	0	542	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	1,787	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	597	0	597	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	41,994	0	2,185	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,555,000	179,370	702,173	340,997	566,697	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.120011	13.050786	8.457470	26.694614	2.976881	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	371,731	30,681	79,548	94,243	55,606	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.927292	2.232320	0.958133	7.377720	0.292100	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/25/2014 10:27 am

		Cost Center Description	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (MEDICAL SUPPLIES)	
			12.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	152,634				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	661,563			14.00
15.00	01500	PHARMACY	0	0	2,616	1,000		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	24	0	56,308,666	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	40,773	76,264	0	3,909,166	30.00
43.00	04300	NURSERY	0	3,871	9,634	0	592,538	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,840	262,057	0	7,805,253	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,138	32,697	0	2,011,158	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,010	17,677	0	13,561,560	54.00
60.00	06000	LABORATORY	0	18,799	23,600	0	10,473,645	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,585	11,441	0	1,417,230	65.00
66.00	06600	PHYSICAL THERAPY	0	0	19,681	0	4,143,999	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	486,559	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,914	0	0	157,263	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	48,857	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	53,003	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	34,704	104,012	0	11,750,295	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	152,634	661,563	1,000	56,308,666	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,651,779	505,999	1,067,790	403,561	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	10.821829	0.764854	1,067.790000	0.007167	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	133,064	129,580	91,868	78,498	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.871785	0.195869	91.868000	0.001394	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,320,027		4,320,027	0	0	30.00
43.00	04300	NURSERY	360,335		360,335	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,512,921		2,512,921	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,249,007		1,249,007	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,028,739		2,028,739	0	0	54.00
60.00	06000	LABORATORY	2,373,529		2,373,529	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	576,779	0	576,779	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,086,563	0	1,086,563	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	262,041	0	262,041	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	191,228	0	191,228	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	302,370		302,370	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	111,780		111,780	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,067,790		1,067,790	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,787,174		3,787,174	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	493,259		493,259		0	92.00
200.00		Subtotal (see instructions)	20,723,542	0	20,723,542	0	0	200.00
201.00		Less Observation Beds	493,259		493,259		0	201.00
202.00		Total (see instructions)	20,230,283	0	20,230,283	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,479,798		3,479,798			30.00
43.00	04300	NURSERY	592,538		592,538			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,289,328	6,515,925	7,805,253	0.321953	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,392,324	618,834	2,011,158	0.621039	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	491,679	13,069,881	13,561,560	0.149595	0.000000	54.00
60.00	06000	LABORATORY	780,462	9,693,183	10,473,645	0.226619	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	622,409	794,821	1,417,230	0.406976	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	810,592	2,863,367	3,673,959	0.295747	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	450,801	505,798	956,599	0.273930	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	77,746	79,517	157,263	1.215976	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	856,371	1,037,529	1,893,900	0.159655	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	203,193	59,894	263,087	0.424878	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,982,896	2,324,977	5,307,873	0.201171	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	24,646	11,725,649	11,750,295	0.322305	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	429,368	429,368	1.148802	0.000000	92.00
200.00		Subtotal (see instructions)	14,054,783	49,718,743	63,773,526			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,054,783	49,718,743	63,773,526			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
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: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/25/2014 10:27 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	4,320,027		4,320,027	0	4,320,027	30.00
43.00	04300	NURSERY	360,335		360,335	0	360,335	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,512,921		2,512,921	0	2,512,921	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,249,007		1,249,007	0	1,249,007	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,028,739		2,028,739	0	2,028,739	54.00
60.00	06000	LABORATORY	2,373,529		2,373,529	0	2,373,529	60.00
65.00	06500	RESPIRATORY THERAPY	576,779	0	576,779	0	576,779	65.00
66.00	06600	PHYSICAL THERAPY	1,086,563	0	1,086,563	0	1,086,563	66.00
67.00	06700	OCCUPATIONAL THERAPY	262,041	0	262,041	0	262,041	67.00
68.00	06800	SPEECH PATHOLOGY	191,228	0	191,228	0	191,228	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	302,370		302,370	0	302,370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	111,780		111,780	0	111,780	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,067,790		1,067,790	0	1,067,790	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,787,174		3,787,174	0	3,787,174	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	493,259		493,259		493,259	92.00
200.00		Subtotal (see instructions)	20,723,542	0	20,723,542	0	20,723,542	200.00
201.00		Less Observation Beds	493,259		493,259		493,259	201.00
202.00		Total (see instructions)	20,230,283	0	20,230,283	0	20,230,283	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/25/2014 10:27 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,479,798		3,479,798			30.00
43.00	04300	NURSERY	592,538		592,538			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,289,328	6,515,925	7,805,253	0.321953	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,392,324	618,834	2,011,158	0.621039	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	491,679	13,069,881	13,561,560	0.149595	0.000000	54.00
60.00	06000	LABORATORY	780,462	9,693,183	10,473,645	0.226619	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	622,409	794,821	1,417,230	0.406976	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	810,592	2,863,367	3,673,959	0.295747	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	450,801	505,798	956,599	0.273930	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	77,746	79,517	157,263	1.215976	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	856,371	1,037,529	1,893,900	0.159655	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	203,193	59,894	263,087	0.424878	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,982,896	2,324,977	5,307,873	0.201171	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	24,646	11,725,649	11,750,295	0.322305	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	429,368	429,368	1.148802	0.000000	92.00
200.00		Subtotal (see instructions)	14,054,783	49,718,743	63,773,526			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,054,783	49,718,743	63,773,526			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/25/2014 10:27 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part II Date/Time Prepared: 11/25/2014 10:27 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,512,921	365,190	2,147,731	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,249,007	101,853	1,147,154	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,028,739	249,337	1,779,402	0	0	54.00
60.00	06000	LABORATORY	2,373,529	166,838	2,206,691	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	576,779	56,961	519,818	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,086,563	109,661	976,902	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	262,041	13,336	248,705	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	191,228	19,684	171,544	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	302,370	17,165	285,205	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	111,780	12,424	99,356	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,067,790	91,868	975,922	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,787,174	283,838	3,503,336	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	493,259	117,347	375,912	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	16,043,180	1,605,502	14,437,678	0	0	200.00
201.00		Less Observation Beds	493,259	117,347	375,912	0	0	201.00
202.00		Total (line 200 minus line 201)	15,549,921	1,488,155	14,061,766	0	0	202.00

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

Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part II Date/Time Prepared: 11/25/2014 10:27 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,512,921	7,805,253	0.321953		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,249,007	2,011,158	0.621039		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,028,739	13,561,560	0.149595		54.00
60.00	06000	LABORATORY	2,373,529	10,473,645	0.226619		60.00
65.00	06500	RESPIRATORY THERAPY	576,779	1,417,230	0.406976		65.00
66.00	06600	PHYSICAL THERAPY	1,086,563	3,673,959	0.295747		66.00
67.00	06700	OCCUPATIONAL THERAPY	262,041	956,599	0.273930		67.00
68.00	06800	SPEECH PATHOLOGY	191,228	157,263	1.215976		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	302,370	1,893,900	0.159655		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	111,780	263,087	0.424878		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,067,790	5,307,873	0.201171		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,787,174	11,750,295	0.322305		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	493,259	429,368	1.148802		92.00
200.00		Subtotal (sum of lines 50 thru 199)	16,043,180	59,701,190			200.00
201.00		Less Observation Beds	493,259	0			201.00
202.00		Total (line 200 minus line 201)	15,549,921	59,701,190			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	365,190	7,805,253	0.046788	452,566	21,175	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	101,853	2,011,158	0.050644	5,640	286	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	249,337	13,561,560	0.018386	260,291	4,786	54.00
60.00	06000	LABORATORY	166,838	10,473,645	0.015929	446,987	7,120	60.00
65.00	06500	RESPIRATORY THERAPY	56,961	1,417,230	0.040192	501,948	20,174	65.00
66.00	06600	PHYSICAL THERAPY	109,661	3,673,959	0.029848	176,853	5,279	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,336	956,599	0.013941	103,578	1,444	67.00
68.00	06800	SPEECH PATHOLOGY	19,684	157,263	0.125166	28,837	3,609	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,165	1,893,900	0.009063	348,666	3,160	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,424	263,087	0.047224	91,467	4,319	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91,868	5,307,873	0.017308	1,421,398	24,602	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	283,838	11,750,295	0.024156	24,275	586	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	117,347	429,368	0.273302	0	0	92.00
200.00		Total (lines 50-199)	1,605,502	59,701,190		3,862,506	96,540	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,805,253	0.000000	0.000000	452,566	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,011,158	0.000000	0.000000	5,640	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,561,560	0.000000	0.000000	260,291	54.00
60.00	06000	LABORATORY	0	10,473,645	0.000000	0.000000	446,987	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,417,230	0.000000	0.000000	501,948	65.00
66.00	06600	PHYSICAL THERAPY	0	3,673,959	0.000000	0.000000	176,853	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	956,599	0.000000	0.000000	103,578	67.00
68.00	06800	SPEECH PATHOLOGY	0	157,263	0.000000	0.000000	28,837	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,893,900	0.000000	0.000000	348,666	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	263,087	0.000000	0.000000	91,467	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,307,873	0.000000	0.000000	1,421,398	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	11,750,295	0.000000	0.000000	24,275	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	429,368	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	59,701,190			3,862,506	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.321953	0	1,421,419	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.621039	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149595	0	3,471,968	0	0	54.00
60.00	06000	LABORATORY	0.226619	0	2,932,275	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.406976	0	418,194	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.295747	0	895,130	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273930	0	152,458	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.215976	0	7,659	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.159655	0	301,459	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.424878	0	39,746	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201171	0	1,047,565	18,911	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.322305	0	3,034,359	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.148802	0	123,898	0	0	92.00
200.00		Subtotal (see instructions)		0	13,846,130	18,911	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	13,846,130	18,911	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	457,630	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	519,389	0		54.00
60.00	06000	LABORATORY	664,509	0		60.00
65.00	06500	RESPIRATORY THERAPY	170,195	0		65.00
66.00	06600	PHYSICAL THERAPY	264,732	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	41,763	0		67.00
68.00	06800	SPEECH PATHOLOGY	9,313	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,129	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,887	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	210,740	3,804		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	977,989	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	142,334	0		92.00
200.00		Subtotal (see instructions)	3,523,610	3,804		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,523,610	3,804		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151316 | Component CCN: 15Z316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.321953	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.621039	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149595	0	0	0	0	54.00
60.00	06000	LABORATORY	0.226619	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.406976	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.295747	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273930	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.215976	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.159655	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.424878	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201171	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.322305	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.148802	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151316 | Component CCN: 15Z316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V | Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part I Date/Time Prepared: 11/25/2014 10:27 am

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	795,670	179,670	616,000	2,841	216.83	30.00
43.00	NURSERY	26,727		26,727	462	57.85	43.00
200.00	Total (lines 30-199)	822,397		642,727	3,303		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	144	31,224				30.00
43.00	NURSERY	369	21,347				43.00
200.00	Total (lines 30-199)	513	52,571				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/25/2014 10:27 am

Title XIX | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	365,190	7,805,253	0.046788	363,285	16,997	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	101,853	2,011,158	0.050644	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	249,337	13,561,560	0.018386	28,386	522	54.00
60.00	06000	LABORATORY	166,838	10,473,645	0.015929	182,577	2,908	60.00
65.00	06500	RESPIRATORY THERAPY	56,961	1,417,230	0.040192	28,728	1,155	65.00
66.00	06600	PHYSICAL THERAPY	109,661	3,673,959	0.029848	26,247	783	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,336	956,599	0.013941	5,438	76	67.00
68.00	06800	SPEECH PATHOLOGY	19,684	157,263	0.125166	4,366	546	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,165	1,893,900	0.009063	75,262	682	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,424	263,087	0.047224	17,858	843	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91,868	5,307,873	0.017308	389,006	6,733	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	283,838	11,750,295	0.024156	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	117,347	429,368	0.273302	0	0	92.00
200.00		Total (lines 50-199)	1,605,502	59,701,190		1,121,153	31,245	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part III Date/Time Prepared: 11/25/2014 10:27 am

Title XIX | Hospital | Cost

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,841	0.00	144	0		30.00
43.00	04300	NURSERY	462	0.00	369	0		43.00
200.00		Total (lines 30-199)	3,303		513	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/25/2014 10:27 am

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/25/2014 10:27 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,805,253	0.000000	0.000000	363,285	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,011,158	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,561,560	0.000000	0.000000	28,386	54.00
60.00	06000	LABORATORY	0	10,473,645	0.000000	0.000000	182,577	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,417,230	0.000000	0.000000	28,728	65.00
66.00	06600	PHYSICAL THERAPY	0	3,673,959	0.000000	0.000000	26,247	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	956,599	0.000000	0.000000	5,438	67.00
68.00	06800	SPEECH PATHOLOGY	0	157,263	0.000000	0.000000	4,366	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,893,900	0.000000	0.000000	75,262	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	263,087	0.000000	0.000000	17,858	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,307,873	0.000000	0.000000	389,006	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	11,750,295	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	429,368	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	59,701,190			1,121,153	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/25/2014 10:27 am

Title XIX | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151316	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/25/2014 10:27 am
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,808	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,841	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)	2,422	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	406	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)	406	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	78	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)	77	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,323	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)	406	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)	406	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	126.36	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	126.36	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,320,027	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)	9,856	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)	9,730	25.00
26.00	Total swing-bed cost (see instructions)	975,505	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,344,522	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)	3,344,522	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)	1,177.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,557,489	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)	1,557,489	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	997,761	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,555,250	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)	477,959	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	477,959	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	955,918	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)	419	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,177.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	493,259	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	795,670	3,344,522	0.237902	493,259	117,347	90.00
91.00	Nursing School cost	0	3,344,522	0.000000	493,259	0	91.00
92.00	Allied health cost	0	3,344,522	0.000000	493,259	0	92.00
93.00	All other Medical Education	0	3,344,522	0.000000	493,259	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/25/2014 10:27 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,808	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,841	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)	2,422	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	406	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)	406	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	78	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)	77	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	144	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)	19	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)	462	15.00
16.00	Nursery days (title V or XIX only)	369	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	126.36	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	126.36	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,320,027	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)	9,856	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)	9,730	25.00
26.00	Total swing-bed cost (see instructions)	975,505	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,344,522	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)	3,344,522	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)	1,177.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	169,523	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)	169,523	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/25/2014 10:27 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)	360,335	462	779.95	369	287,802	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)	286,695	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	744,020	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)	2,401	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	2,401	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)	419	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,177.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	493,259	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/25/2014 10:27 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	795,670	3,344,522	0.237902	493,259	117,347	90.00
91.00	Nursing School cost	0	3,344,522	0.000000	493,259	0	91.00
92.00	Allied health cost	0	3,344,522	0.000000	493,259	0	92.00
93.00	All other Medical Education	0	3,344,522	0.000000	493,259	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,290,694		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.321953	452,566	145,705	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.621039	5,640	3,503	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149595	260,291	38,938	54.00
60.00	06000	LABORATORY	0.226619	446,987	101,296	60.00
65.00	06500	RESPIRATORY THERAPY	0.406976	501,948	204,281	65.00
66.00	06600	PHYSICAL THERAPY	0.295747	176,853	52,304	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273930	103,578	28,373	67.00
68.00	06800	SPEECH PATHOLOGY	1.215976	28,837	35,065	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.159655	348,666	55,666	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.424878	91,467	38,862	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201171	1,421,398	285,944	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.322305	24,275	7,824	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.148802	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,862,506	997,761	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,862,506		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3

Component CCN: 15Z316 | Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.321953	18,079	5,821	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.621039	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149595	51,911	7,766	54.00
60.00	06000	LABORATORY	0.226619	95,441	21,629	60.00
65.00	06500	RESPIRATORY THERAPY	0.406976	91,733	37,333	65.00
66.00	06600	PHYSICAL THERAPY	0.295747	474,100	140,214	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273930	264,415	72,431	67.00
68.00	06800	SPEECH PATHOLOGY	1.215976	35,352	42,987	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.159655	89,579	14,302	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.424878	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201171	472,560	95,065	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.322305	371	120	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.148802	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,593,541	437,668	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,593,541		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/25/2014 10:27 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,883,964		30.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.321953	363,285	116,961	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.621039	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149595	28,386	4,246	54.00
60.00	06000	LABORATORY	0.226619	182,577	41,375	60.00
65.00	06500	RESPIRATORY THERAPY	0.406976	28,728	11,692	65.00
66.00	06600	PHYSICAL THERAPY	0.295747	26,247	7,762	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273930	5,438	1,490	67.00
68.00	06800	SPEECH PATHOLOGY	1.215976	4,366	5,309	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.159655	75,262	12,016	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.424878	17,858	7,587	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201171	389,006	78,257	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.322305	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.148802	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,121,153	286,695	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,121,153		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151316	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/25/2014 10:27 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,527,414	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,527,414	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	3,562,688	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	32,408	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,181,569	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	1,348,711	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,348,711	30.00
31.00	Primary payer payments	366	31.00
32.00	Subtotal (line 30 minus line 31)	1,348,345	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)	427,654	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	376,336	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	372,116	36.00
37.00	Subtotal (see instructions)	1,724,681	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,724,681	40.00
40.01	Sequestration adjustment (see instructions)	34,494	40.01
41.00	Interim payments	1,919,162	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-228,975	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: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,240,890		1,919,162	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	02/28/2014	77,400		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)		77,400		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,318,290		1,919,162	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		58,780		228,975	6.02
7.00	Total Medicare program liability (see instructions)		2,259,510		1,690,187	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151316 | Component CCN: 15Z316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 11/25/2014 10:27 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,383,130		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/28/2014	32,400		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)		32,400		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,415,530		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		43,309		0	6.02
7.00	Total Medicare program liability (see instructions)		1,372,221		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151316 Component CCN: 15Z316	Period: From 07/01/2013 To 06/30/2014	Worksheet E-2 Date/Time Prepared: 11/25/2014 10:27 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	965,477	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)	442,045	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	812	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,407,522	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,407,522	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,407,522	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,564	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,399,958	0	15.00
16.00		0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
17.00	Allowable bad debts (see instructions)	304	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	268	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	304	0	18.00
19.00	Total (see instructions)	1,400,226	0	19.00
19.01	Sequestration adjustment (see instructions)	28,005	0	19.01
20.00	Interim payments	1,415,530	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	-43,309	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151316	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part V Date/Time Prepared: 11/25/2014 10:27 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,555,250	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	2,555,250	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,580,803	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,580,803	19.00
20.00	Deductibles (exclude professional component)	295,925	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,284,878	22.00
23.00	Coinsurance	3,256	23.00
24.00	Subtotal (line 22 minus line 23)	2,281,622	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	27,273	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	24,000	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	15,373	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,305,622	28.00
29.00		0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	2,305,622	30.00
30.01	Sequestration adjustment (see instructions)	46,112	30.01
31.00	Interim payments	2,318,290	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32	-58,780	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151316	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 11/25/2014 10:27 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	744,020		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)	744,020	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)	744,020	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	1,883,964		8.00
9.00	Ancillary service charges	1,121,153	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)	3,005,117	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)	3,005,117	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,261,097	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)	744,020	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)	744,020	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)	744,020	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	744,020	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	744,020	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)	744,020	0	40.00
41.00	Interim payments	744,020	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G | Date/Time Prepared: 11/25/2014 10:27 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	45,471,932	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	7,954,298	0	0	0	4.00
5.00	Other receivable	212,863	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,728,574	0	0	0	6.00
7.00	Inventory	495,978	0	0	0	7.00
8.00	Prepaid expenses	402,988	0	0	0	8.00
9.00	Other current assets	3,108,954	0	0	0	9.00
10.00	Due from other funds	-53,693	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	52,864,746	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	160,146	0	0	0	12.00
13.00	Land improvements	66,241	0	0	0	13.00
14.00	Accumulated depreciation	-39,582	0	0	0	14.00
15.00	Buildings	1,906,409	0	0	0	15.00
16.00	Accumulated depreciation	-786,588	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	740,327	0	0	0	19.00
20.00	Accumulated depreciation	-490,433	0	0	0	20.00
21.00	Automobiles and trucks	25,700	0	0	0	21.00
22.00	Accumulated depreciation	-23,344	0	0	0	22.00
23.00	Major movable equipment	5,314,376	0	0	0	23.00
24.00	Accumulated depreciation	-4,522,228	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)	2,351,024	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	31,010	53,693	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	31,010	53,693	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	55,246,780	53,693	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,540,698	0	0	0	37.00
38.00	Salaries, wages, and fees payable	399,633	0	0	0	38.00
39.00	Payroll taxes payable	26,453	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				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,160,638	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,127,422	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	485,715	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	485,715	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	7,613,137	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	47,633,643				52.00
53.00	Specific purpose fund		53,693			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)	47,633,643	53,693	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	55,246,780	53,693	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-1 | Date/Time Prepared: 11/25/2014 10:27 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		38,567,700		34,242		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,912,452				2.00
3.00	Total (sum of line 1 and line 2)		50,480,152		34,242		3.00
4.00	RESTRICTED ASSETS	31,419		0		0	4.00
5.00	DEFERRED PENSION COST	89,807		0		0	5.00
6.00		0		0		0	6.00
7.00	NET ASSETS RELEASED FROM RESTRICTION	0		103,755		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		121,226		103,755		10.00
11.00	Subtotal (line 3 plus line 10)		50,601,378		137,997		11.00
12.00	TRANSFER TO AFFILIATES	2,935,538		0		0	12.00
13.00	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPEC	32,197		0		0	13.00
14.00	NET ASSETS RELEASED FROM RESTRICTION	0		84,304		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		2,967,735		84,304		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		47,633,643		53,693		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	RESTRICTED ASSETS		0		4.00
5.00	DEFERRED PENSION COST		0		5.00
6.00			0		6.00
7.00	NET ASSETS RELEASED FROM RESTRICTION		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	TRANSFER TO AFFILIATES		0		12.00
13.00	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPEC		0		13.00
14.00	NET ASSETS RELEASED FROM RESTRICTION		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: 151316 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/25/2014 10:27 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,083,494		6,083,494	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)	6,083,494		6,083,494	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)	6,083,494		6,083,494	17.00
18.00	Ancillary services	8,216,084	37,294,284	45,510,368	18.00
19.00	Outpatient services	0	12,179,663	12,179,663	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	158,168	158,168	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,299,578	49,632,115	63,931,693	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,519,637		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		22,519,637		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151316	Period: From 07/01/2013 To 06/30/2014	Worksheet G-3 Date/Time Prepared: 11/25/2014 10:27 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	63,931,693	1.00
2.00	Less contractual allowances and discounts on patients' accounts	34,592,990	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,338,703	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,519,637	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,819,066	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,770,830	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	113,953	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	11,095	17.00
18.00	Revenue from sale of medical records and abstracts	8,810	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	129,420	22.00
23.00	Governmental appropriations	0	23.00
24.00	NET ASSETS RELEASED FROM RESTRICTION	64,006	24.00
24.01	MISC INCOME	16,086	24.01
24.02	FOUNDATION	5,480	24.02
24.03	OTHER - UNREALIZED LOSSES	2,973,706	24.03
25.00	Total other income (sum of lines 6-24)	5,093,386	25.00
26.00	Total (line 5 plus line 25)	11,912,452	26.00
27.00	OTHER	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)	11,912,452	29.00