This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151303	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/24/2014 2:39 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/24/2014 Time: 2:39 pm
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 JENNINGS HOSPITAL (151303) 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	-212,643	-147,695	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	-142,110	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	-354,753	-147,695	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: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2014 12:32 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 301 HENRY STREET	PO Box:			1.00
2.00	City: NORTH VERNON	State: IN	Zip Code: 47265	County: JENNINGS	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 JENNINGS HOSPITAL	151303	99915	1	07/01/1996	N	O	P	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 JENNINGS SWING BED	15Z303	99915		07/05/1991	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: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2014 12:32 pm

		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: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2014 12:32 pm

		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: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2014 12:32 pm

		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

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		V	XIX	
		1.00	2.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		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	Y	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:	1	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for 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: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2014 12:32 pm

		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	15HO46	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 10330 N. MERIDAN ST	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: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2014 12:32 pm

		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.	Y	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: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/21/2014 12:32 pm

		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				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	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.				Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				Y	33.00
	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: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/21/2014 12:32 pm

		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: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2014 12:32 pm

	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	27,168.00	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	27,168.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	27,168.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		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: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2014 12:32 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	701	76	1,132			1.00
2.00	HMO and other (see instructions)	102	49				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	448	0	448			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	45			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,149	76	1,625			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)	1,149	76	1,625	0.00	98.19	14.00
15.00	CAH visits	9,224	2,347	29,942			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	98.19	27.00
28.00	Observation Bed Days		0	578			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			5			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2014 12:32 pm

	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	205	33	407	1.00
2.00	HMO and other (see instructions)			33	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	205	33	407	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
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: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-10 | Date/Time Prepared: 11/21/2014 12:32 pm

		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)	0.248990	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	326,505	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	11,072,298	6.00
7.00	Medicaid cost (line 1 times line 6)	2,756,891	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,430,386	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	11,646	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,430,386	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	5,411,793	35,955	5,447,748	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,347,482	8,952	1,356,434	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)	1,347,482	8,952	1,356,434	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)	2,597,056	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	597,846	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,999,210	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	497,783	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,854,217	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,284,603	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/21/2014 12:32 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		744,810	744,810	-33,929	710,881	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	144,650	1,579,350	1,724,000	-6	1,723,994	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,349,332	2,309,177	3,658,509	33,755	3,692,264	5.00
7.00	00700	OPERATION OF PLANT	110,792	694,251	805,043	-239	804,804	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	54,824	54,824	0	54,824	8.00
9.00	00900	HOUSEKEEPING	0	292,875	292,875	0	292,875	9.00
10.00	01000	DIETARY	0	242,698	242,698	-162,559	80,139	10.00
11.00	01100	CAFETERIA	0	0	0	162,559	162,559	11.00
13.00	01300	NURSING ADMINISTRATION	122,366	26,847	149,213	-30	149,183	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	109,117	32,495	141,612	0	141,612	14.00
15.00	01500	PHARMACY	182,469	436,273	618,742	-28	618,714	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130,190	51,553	181,743	-6	181,737	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	962,532	348,854	1,311,386	-7,683	1,303,703	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	349,478	328,161	677,639	-20,695	656,944	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	783,654	995,037	1,778,691	-4,319	1,774,372	54.00
60.00	06000	LABORATORY	11,077	1,103,049	1,114,126	-39	1,114,087	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,471	2,471	-546	1,925	65.00
66.00	06600	PHYSICAL THERAPY	0	241,374	241,374	-572	240,802	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	29,129	29,129	0	29,129	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,728	1,728	0	1,728	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,952	10,952	49,579	60,531	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	158,459	158,459	0	158,459	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	893,609	964,526	1,858,135	-15,214	1,842,921	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,149,266	10,648,893	15,798,159	28	15,798,187	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	27,039	27,039	0	27,039	194.00
194.02	07952	OUTPATIENT CLINICS	2,429	2,562	4,991	-28	4,963	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07955	SPN	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	5,151,695	10,678,494	15,830,189	0	15,830,189	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/21/2014 12:32 pm

		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	-307,655	403,226		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-33,766	1,690,228		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-358,779	3,333,485		5.00
7.00	00700	OPERATION OF PLANT	-15,092	789,712		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	54,824		8.00
9.00	00900	HOUSEKEEPING	-14,644	278,231		9.00
10.00	01000	DIETARY	-3,912	76,227		10.00
11.00	01100	CAFETERIA	-44,093	118,466		11.00
13.00	01300	NURSING ADMINISTRATION	0	149,183		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	141,612		14.00
15.00	01500	PHARMACY	-65,353	553,361		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,593	172,144		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-157,090	1,146,613		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	656,944		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-109,668	1,664,704		54.00
60.00	06000	LABORATORY	-16,455	1,097,632		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,925		65.00
66.00	06600	PHYSICAL THERAPY	0	240,802		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	29,129		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,728		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	60,531		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	158,459		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	-267,133	1,575,788		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,403,233	14,394,954		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	27,039		194.00
194.02	07952	OUTPATIENT CLINICS	0	4,963		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	100,945	100,945		194.03
194.04	07955	SPN	0	0		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-1,302,288	14,527,901		200.00

RECLASSIFICATIONS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/21/2014 12:32 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	0	162,559		1.00
	TOTALS		0	162,559		
	B - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,929		1.00
	TOTALS		0	33,929		
	C - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	49,579		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
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
	TOTALS		0	49,579		
500.00	Grand Total: Increases		0	246,067		500.00

RECLASSIFICATIONS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/21/2014 12:32 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	0	162,559	0		1.00
	TOTALS		0	162,559			
	B - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	33,929	9		1.00
	TOTALS		0	33,929			
	C - MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	174	0		2.00
3.00	OPERATION OF PLANT	7.00	0	239	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	30	0		4.00
6.00	PHARMACY	15.00	0	28	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	6	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	7,683	0		8.00
9.00	OPERATING ROOM	50.00	0	20,695	0		9.00
10.00	RADIOLOGY - DIAGNOSTIC	54.00	0	4,319	0		10.00
11.00	LABORATORY	60.00	0	39	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	546	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	572	0		13.00
14.00	EMERGENCY	91.00	0	15,214	0		14.00
15.00	OUTPATIENT CLINICS	194.02	0	28	0		15.00
	TOTALS		0	49,579			
500.00	Grand Total: Decreases		0	246,067			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 11/21/2014 12:32 pm

		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	127,944	0	0	0	0	1.00
2.00	Land Improvements	409,779	0	0	0	0	2.00
3.00	Buildings and Fixtures	13,643,807	57,285	0	57,285	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	968,285	0	0	0	0	5.00
6.00	Movable Equipment	3,336,861	63,205	0	63,205	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,486,676	120,490	0	120,490	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	18,486,676	120,490	0	120,490	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	127,944	0	1.00
2.00	Land Improvements	409,779	0	2.00
3.00	Buildings and Fixtures	13,701,092	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	968,285	0	5.00
6.00	Movable Equipment	3,400,066	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,607,166	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	18,607,166	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 11/21/2014 12:32 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	390,189	0	341,584	13,037	0	1.00
3.00	Total (sum of lines 1-2)	390,189	0	341,584	13,037	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	744,810				1.00
3.00	Total (sum of lines 1-2)	0	744,810				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 11/21/2014 12:32 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	18,607,166	0	18,607,166	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	18,607,166	0	18,607,166	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	170,058	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	170,058	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	220,131	13,037	0	0	403,226	1.00
3.00	Total (sum of lines 1-2)	220,131	13,037	0	0	403,226	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/21/2014 12:32 pm

	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	-186,202	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-20,535	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-5,431	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-543,998			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	689,325			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-44,093	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-9,593	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,244	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	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	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00			0		0.00	0	33.00
33.02	CHARITABLE EXPENSE	A	-13,525	ADMINISTRATIVE & GENERAL	5.00	0	33.02

ADJUSTMENTS TO EXPENSES | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/21/2014 12:32 pm

	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	
33.03	AHA & IHA DUES	A	-621	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.06	MISC REVENUE	B	-340	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	MISC REVENUE	B	-65,353	PHARMACY	15.00	0	33.07
33.08	MISC REVENUE	B	-5,274	LABORATORY	60.00	0	33.08
33.09	PHYSICIAN HOUSEKEEPING	A	-14,644	HOUSEKEEPING	9.00	0	33.09
33.10	PHYSICIAN PLANT OPS	A	-9,661	OPERATION OF PLANT	7.00	0	33.10
33.11	PHYSICIAN BENEFITS	A	-447	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	MISC REVENUE	B	-3,912	DIETARY	10.00	0	33.12
33.13	MISC REVENUE	B	-1,109	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	ENTERTAINMENT	A	-68	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	ENTERTAINMENT	A	-302	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	ENTERTAINMENT	A	-104	LABORATORY	60.00	0	33.16
33.17	HOSPITAL PROVIDER TAX	A	-1,052,272	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	PROFFESIONAL COMPONENT BENEFITS	A	-12,885	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19			0		0.00	0	33.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,302,288				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-1 | Date/Time Prepared: 11/21/2014 12:32 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,594,980	850,757	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	0	70,807	2.00
3.00	194.03	OTHER NONREIMBURSABLE COST C	HOME OFFICE	100,945	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION CHARGEBACKS	181,569	181,569	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	ASCENSION CHARGEBACKS	761,242	761,242	4.01
4.02	7.00	OPERATION OF PLANT	ASCENSION CHARGEBACKS	177,504	177,504	4.02
4.03	0.00			0	0	4.03
4.04	14.00	CENTRAL SERVICES & SUPPLY	ASCENSION CHARGEBACKS	112,623	112,623	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	ASCENSION CHARGEBACKS	89,328	89,328	4.05
4.06	0.00			0	0	4.06
4.07	54.00	RADIOLOGY - DIAGNOSTIC	ASCENSION CHARGEBACKS	13,224	13,224	4.07
4.08	91.00	EMERGENCY	ASCENSION CHARGEBACKS	26,664	26,664	4.08
4.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE SELF-INSURANCE	670,165	763,351	4.09
4.10	0.00			0	0	4.10
4.11	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	186,202	307,655	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	20,535	33,929	4.12
4.13	0.00			0	0	4.13
4.14	54.00	RADIOLOGY - DIAGNOSTIC	TRIMEDX	97,024	97,654	4.14
4.15	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	201,245	57,618	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	0.00			0	0	4.18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
4.21	0.00			0	0	4.21
4.22	0.00			0	0	4.22
5.00	0		0	4,233,250	3,543,925	5.00

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

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

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

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

6.00	G	ST. VINCENT HEA	100.00	ST. VINCENT HEA	100.00	6.00
7.00	B	ST. VINCENT HOS	100.00	ST. VINCENT HOS	100.00	7.00
8.00	G	ASCENSION	100.00	ASCENSION	100.00	8.00
9.00	A	TRIMEDX	0.00	TRIMEDX	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 151303	Period: From 07/01/2013 To 06/30/2014	Worksheet A-8-1 Date/Time Prepared: 11/21/2014 12:32 pm

	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	744,223	0		1.00
2.00	-70,807	0		2.00
3.00	100,945	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	-93,186	0		4.09
4.10	0	0		4.10
4.11	-121,453	11		4.11
4.12	-13,394	0		4.12
4.13	0	0		4.13
4.14	-630	0		4.14
4.15	143,627	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
5.00	689,325			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 11/21/2014 12:32 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	156,750	156,750	0	0	0	1.00
2.00	54.00	RADIOLOGY - DIAGNOSTIC	109,038	109,038	0	0	0	2.00
3.00	60.00	LABORATORY	11,077	11,077	0	0	0	3.00
4.00	91.00	EMERGENCY	853,082	267,133	585,949	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,129,947	543,998	585,949		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	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	156,750		1.00
2.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	109,038		2.00
3.00	60.00	LABORATORY	0	0	0	11,077		3.00
4.00	91.00	EMERGENCY	0	0	0	267,133		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	543,998		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/21/2014 12:32 pm

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)					214	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)					46	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.21	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,673.00	1,950.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.05	57.79	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.53	38.53	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)					128,905	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					112,691	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					241,596	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)					241,596	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)					241,596	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)					8,245	24.00
25.00	Assistants (line 4 times column 3, line 11)					1,329	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,574	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)					1,355	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					10,929	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)					10,929	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: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2014 12:32 pm

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	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)	241,596		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	10,929		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)	252,525		63.00
64.00	Total cost of outside supplier services (from your records)	235,357		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	9,574		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,355		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	10,929		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	1,355		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	1,355		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151303	Period: From 07/01/2013 To 06/30/2014	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/21/2014 12:32 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		49	1.00
2.00	Line 1 multiplied by 15 hours per week		735	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		100	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	382.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.04	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.52	36.52	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	27,901	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	27,901	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)	27,901	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)	73.04	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	53,684	22.00
23.00	Total salary equivalency (see instructions)	53,684	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)	3,652	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	3,652	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)	521	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	4,173	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)	4,173	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: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2014 12:32 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	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	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	53,684	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	4,173	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)	57,857	63.00
64.00	Total cost of outside supplier services (from your records)	29,073	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	3,652	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	521	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	4,173	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	521	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	521	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/21/2014 12:32 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					14	1.00
2.00	Line 1 multiplied by 15 hours per week					210	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					14	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	16.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	70.20	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	35.10	35.10	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					1,123	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					1,123	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)					1,123	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)					70.19	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					14,740	22.00
23.00	Total salary equivalency (see instructions)					14,740	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)					491	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)					491	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)					73	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					564	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)					564	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: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2014 12:32 pm

Speech Pathology | 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)	70.20	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	14,740	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	564	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)	15,304	63.00
64.00	Total cost of outside supplier services (from your records)	1,644	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	491	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	73	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	564	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	73	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	73	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: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/21/2014 12:32 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	403,226	403,226				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,690,228	0	1,690,228			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,333,485	35,623	455,494	3,824,602	3,824,602	5.00
7.00	00700	OPERATION OF PLANT	789,712	36,810	37,400	863,922	308,704	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	54,824	438	0	55,262	19,747	8.00
9.00	00900	HOUSEKEEPING	278,231	8,276	0	286,507	102,377	9.00
10.00	01000	DIETARY	76,227	4,080	0	80,307	28,696	10.00
11.00	01100	CAFETERIA	118,466	8,409	0	126,875	45,336	11.00
13.00	01300	NURSING ADMINISTRATION	149,183	957	41,307	191,447	68,410	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	141,612	6,708	36,835	185,155	66,161	14.00
15.00	01500	PHARMACY	553,361	3,775	61,596	618,732	221,091	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	172,144	31,934	43,948	248,026	88,627	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,146,613	37,830	324,922	1,509,365	539,340	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	656,944	30,061	117,973	804,978	287,642	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,664,704	24,361	264,538	1,953,603	698,082	54.00
60.00	06000	LABORATORY	1,097,632	10,161	3,739	1,111,532	397,183	60.00
65.00	06500	RESPIRATORY THERAPY	1,925	0	0	1,925	688	65.00
66.00	06600	PHYSICAL THERAPY	240,802	9,751	0	250,553	89,530	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,129	0	0	29,129	10,409	67.00
68.00	06800	SPEECH PATHOLOGY	1,728	0	0	1,728	617	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	60,531	0	0	60,531	21,629	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	158,459	0	0	158,459	56,622	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	1,575,788	24,332	301,656	1,901,776	679,560	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)	14,394,954	273,506	1,689,408	14,264,414	3,730,451	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,086	0	2,086	745	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,559	0	4,559	1,629	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	27,039	0	0	27,039	9,662	194.00
194.02	07952	OUTPATIENT CLINICS	4,963	42,879	820	48,662	17,388	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	100,945	0	0	100,945	36,071	194.03
194.04	07955	SPN	0	80,196	0	80,196	28,656	194.04
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)	14,527,901	403,226	1,690,228	14,527,901	3,824,602	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/21/2014 12:32 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,172,626					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,553	76,562				8.00
9.00	00900	HOUSEKEEPING	29,338	15,317	433,539			9.00
10.00	01000	DIETARY	14,465	0	17,239	140,707		10.00
11.00	01100	CAFETERIA	29,808	0	0	0	202,019	11.00
13.00	01300	NURSING ADMINISTRATION	3,391	0	0	0	3,793	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,781	0	0	0	6,326	14.00
15.00	01500	PHARMACY	13,382	0	11,418	0	6,922	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	113,203	0	0	0	11,030	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	134,103	10,785	60,826	140,707	58,634	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	106,563	27,416	39,798	0	22,000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	86,358	8,044	22,860	0	43,943	54.00
60.00	06000	LABORATORY	36,018	0	34,253	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	34,568	4,184	22,835	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	86,256	8,370	94,075	0	49,052	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	712,787	74,116	303,304	140,707	201,700	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	7,396	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,160	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	8,155	0	0	194.00
194.02	07952	OUTPATIENT CLINICS	152,000	2,446	31,643	0	319	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07955	SPN	284,283	0	90,437	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,172,626	76,562	433,539	140,707	202,019	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/21/2014 12:32 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	267,041					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	281,423				14.00
15.00	01500	PHARMACY	0	78	871,623			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16	0	460,902		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	116,527	21,445	0	35,006	2,626,738	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,711	57,773	0	48,780	1,404,661	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	9,711	12,057	0	150,659	2,985,317	54.00
60.00	06000	LABORATORY	4,855	110	0	92,038	1,675,989	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,523	0	1,996	6,132	65.00
66.00	06600	PHYSICAL THERAPY	0	1,598	0	11,747	415,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,612	41,150	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	65	2,410	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	34,383	0	0	116,543	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	109,893	0	0	324,974	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	871,623	0	871,623	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	126,237	42,470	0	118,999	3,106,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	267,041	281,346	871,623	460,902	13,577,347	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	10,227	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	22,348	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	44,856	194.00
194.02	07952	OUTPATIENT CLINICS	0	77	0	0	252,535	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	137,016	194.03
194.04	07955	SPN	0	0	0	0	483,572	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	267,041	281,423	871,623	460,902	14,527,901	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/21/2014 12:32 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,626,738		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,404,661		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	2,985,317		54.00
60.00	06000	LABORATORY	0	1,675,989		60.00
65.00	06500	RESPIRATORY THERAPY	0	6,132		65.00
66.00	06600	PHYSICAL THERAPY	0	415,015		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	41,150		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,410		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	116,543		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	324,974		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	871,623		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	3,106,795		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)	0	13,577,347		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	10,227		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	22,348		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	44,856		194.00
194.02	07952	OUTPATIENT CLINICS	0	252,535		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	137,016		194.03
194.04	07955	SPN	0	483,572		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	14,527,901		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 11/21/2014 12:32 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	629	0	629	629		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	280,016	35,623	315,639	169	315,808	5.00
7.00	00700	OPERATION OF PLANT	2,425	36,810	39,235	14	25,491	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	438	438	0	1,631	8.00
9.00	00900	HOUSEKEEPING	119	8,276	8,395	0	8,454	9.00
10.00	01000	DIETARY	2,008	4,080	6,088	0	2,370	10.00
11.00	01100	CAFETERIA	0	8,409	8,409	0	3,744	11.00
13.00	01300	NURSING ADMINISTRATION	3,081	957	4,038	15	5,649	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,194	6,708	7,902	14	5,463	14.00
15.00	01500	PHARMACY	56,782	3,775	60,557	23	18,256	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	355	31,934	32,289	16	7,318	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	93,632	37,830	131,462	121	44,535	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	97,231	30,061	127,292	44	23,752	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	530,655	24,361	555,016	99	57,638	54.00
60.00	06000	LABORATORY	0	10,161	10,161	1	32,797	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	57	65.00
66.00	06600	PHYSICAL THERAPY	1,244	9,751	10,995	0	7,393	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	859	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	51	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,830	0	3,830	0	1,786	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	4,675	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	11,253	24,332	35,585	113	56,114	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)	1,084,454	273,506	1,357,960	629	308,033	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,086	2,086	0	62	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,559	4,559	0	135	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	798	194.00
194.02	07952	OUTPATIENT CLINICS	323	42,879	43,202	0	1,436	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	2,978	194.03
194.04	07955	SPN	0	80,196	80,196	0	2,366	194.04
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)	1,084,777	403,226	1,488,003	629	315,808	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/21/2014 12:32 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	64,740					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	86	2,155				8.00
9.00	00900	HOUSEKEEPING	1,620	431	18,900			9.00
10.00	01000	DIETARY	799	0	752	10,009		10.00
11.00	01100	CAFETERIA	1,646	0	0	0	13,799	11.00
13.00	01300	NURSING ADMINISTRATION	187	0	0	0	259	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,313	0	0	0	432	14.00
15.00	01500	PHARMACY	739	0	498	0	473	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,250	0	0	0	753	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,404	304	2,652	10,009	4,004	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,883	771	1,735	0	1,503	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	4,768	226	997	0	3,002	54.00
60.00	06000	LABORATORY	1,989	0	1,493	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,908	118	995	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	4,762	236	4,100	0	3,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,354	2,086	13,222	10,009	13,777	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	408	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	892	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	356	0	0	194.00
194.02	07952	OUTPATIENT CLINICS	8,392	69	1,379	0	22	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07955	SPN	15,694	0	3,943	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	64,740	2,155	18,900	10,009	13,799	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/21/2014 12:32 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	10,148					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,124				14.00
15.00	01500	PHARMACY	0	4	80,550			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1	0	46,627		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,428	1,153	0	3,542	209,614	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	369	3,105	0	4,936	169,390	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	369	648	0	15,232	637,995	54.00
60.00	06000	LABORATORY	185	6	0	9,314	55,946	60.00
65.00	06500	RESPIRATORY THERAPY	0	82	0	202	341	65.00
66.00	06600	PHYSICAL THERAPY	0	86	0	1,189	22,684	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	163	1,022	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7	58	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,848	0	0	7,464	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	5,905	0	0	10,580	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	80,550	0	80,550	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	4,797	2,282	0	12,042	123,382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,148	15,120	80,550	46,627	1,319,026	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	2,556	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	5,586	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	1,154	194.00
194.02	07952	OUTPATIENT CLINICS	0	4	0	0	54,504	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	2,978	194.03
194.04	07955	SPN	0	0	0	0	102,199	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	10,148	15,124	80,550	46,627	1,488,003	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/21/2014 12:32 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	209,614		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	169,390		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	637,995		54.00
60.00	06000	LABORATORY	0	55,946		60.00
65.00	06500	RESPIRATORY THERAPY	0	341		65.00
66.00	06600	PHYSICAL THERAPY	0	22,684		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,022		67.00
68.00	06800	SPEECH PATHOLOGY	0	58		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,464		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	10,580		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	80,550		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	123,382		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)	0	1,319,026		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,556		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,586		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	1,154		194.00
194.02	07952	OUTPATIENT CLINICS	0	54,504		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	2,978		194.03
194.04	07955	SPN	0	102,199		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	1,488,003		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/21/2014 12:32 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	69,965					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,007,045				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,181	1,349,332	-3,824,602	10,703,299		5.00
7.00	00700	OPERATION OF PLANT	6,387	110,792	0	863,922	57,397	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	76	0	0	55,262	76	8.00
9.00	00900	HOUSEKEEPING	1,436	0	0	286,507	1,436	9.00
10.00	01000	DIETARY	708	0	0	80,307	708	10.00
11.00	01100	CAFETERIA	1,459	0	0	126,875	1,459	11.00
13.00	01300	NURSING ADMINISTRATION	166	122,366	0	191,447	166	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,164	109,117	0	185,155	1,164	14.00
15.00	01500	PHARMACY	655	182,469	0	618,732	655	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,541	130,190	0	248,026	5,541	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,564	962,532	0	1,509,365	6,564	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,216	349,478	0	804,978	5,216	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	4,227	783,654	0	1,953,603	4,227	54.00
60.00	06000	LABORATORY	1,763	11,077	0	1,111,532	1,763	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,925	0	65.00
66.00	06600	PHYSICAL THERAPY	1,692	0	0	250,553	1,692	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	29,129	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,728	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	60,531	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	158,459	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	4,222	893,609	0	1,901,776	4,222	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,457	5,004,616	-3,824,602	10,439,812	34,889	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	362	0	0	2,086	362	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	791	0	0	4,559	791	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	27,039	0	194.00
194.02	07952	OUTPATIENT CLINICS	7,440	2,429	0	48,662	7,440	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	100,945	0	194.03
194.04	07955	SPN	13,915	0	0	80,196	13,915	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	403,226	1,690,228		3,824,602	1,172,626	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.763253	0.337570		0.357329	20.430092	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		629		315,808	64,740	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000126		0.029506	1.127934	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/21/2014 12:32 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (ITEMIZED BILLS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56,633					8.00
9.00	00900	HOUSEKEEPING	11,330	17,277				9.00
10.00	01000	DIETARY	0	687	100			10.00
11.00	01100	CAFETERIA	0	0	0	134,125		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,518	110	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	4,200	0	14.00
15.00	01500	PHARMACY	0	455	0	4,596	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	7,323	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,978	2,424	100	38,928	48	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,280	1,586	0	14,606	4	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	5,950	911	0	29,175	4	54.00
60.00	06000	LABORATORY	0	1,365	0	0	2	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,095	910	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	6,191	3,749	0	32,567	52	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	54,824	12,087	100	133,913	110	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	325	0	0	0	194.00
194.02	07952	OUTPATIENT CLINICS	1,809	1,261	0	212	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07955	SPN	0	3,604	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	76,562	433,539	140,707	202,019	267,041	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.351897	25.093419	1,407.070000	1.506199	2,427.645455	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,155	18,900	10,009	13,799	10,148	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.038052	1.093940	100.090000	0.102882	92.254545	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/21/2014 12:32 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	405,798				14.00
15.00	01500	PHARMACY	113	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23	0	50,641,988		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	30,923	0	3,846,351		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	83,306	0	5,359,865		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	17,386	0	16,553,023		54.00
60.00	06000	LABORATORY	159	0	10,112,954		60.00
65.00	06500	RESPIRATORY THERAPY	2,196	0	219,351		65.00
66.00	06600	PHYSICAL THERAPY	2,304	0	1,290,779		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	177,136		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	7,110		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,579	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	158,459	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	61,239	0	13,075,419		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	405,687	100	50,641,988		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.02	07952	OUTPATIENT CLINICS	111	0	0		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.03
194.04	07955	SPN	0	0	0		194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	281,423	871,623	460,902		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.693505	8,716.230000	0.009101		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,124	80,550	46,627		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.037270	805.500000	0.000921		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 12:32 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,626,738		2,626,738	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,404,661		1,404,661	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,985,317		2,985,317	0	0	54.00
60.00	06000	LABORATORY	1,675,989		1,675,989	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,132	0	6,132	0	0	65.00
66.00	06600	PHYSICAL THERAPY	415,015	0	415,015	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,150	0	41,150	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,410	0	2,410	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,543		116,543	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	324,974		324,974	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	871,623		871,623	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
91.00	09100	EMERGENCY	3,106,795		3,106,795	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	702,027		702,027		0	92.00
200.00		Subtotal (see instructions)	14,279,374	0	14,279,374	0	0	200.00
201.00		Less Observation Beds	702,027		702,027		0	201.00
202.00		Total (see instructions)	13,577,347	0	13,577,347	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 12:32 pm

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	1,964,505		1,964,505			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,137	5,310,728	5,359,865	0.262070	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	307,246	16,245,777	16,553,023	0.180349	0.000000	54.00
60.00	06000	LABORATORY	531,120	9,549,111	10,080,231	0.166265	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	167,505	51,846	219,351	0.027955	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	248,810	1,041,969	1,290,779	0.321523	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	69,108	108,028	177,136	0.232307	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,335	4,775	7,110	0.338959	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	456,001	715,725	1,171,726	0.099463	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	564	375,828	376,392	0.863392	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	903,500	1,795,536	2,699,036	0.322939	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
91.00	09100	EMERGENCY	6,886	12,924,653	12,931,539	0.240249	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,368	1,691,620	1,698,988	0.413203	0.000000	92.00
200.00		Subtotal (see instructions)	4,714,085	49,815,596	54,529,681			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,714,085	49,815,596	54,529,681			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 12:32 pm

Title XVIII | Hospital | Cost

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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 12:32 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,626,738		2,626,738	0	2,626,738	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,404,661		1,404,661	0	1,404,661	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,985,317		2,985,317	0	2,985,317	54.00
60.00	06000	LABORATORY	1,675,989		1,675,989	0	1,675,989	60.00
65.00	06500	RESPIRATORY THERAPY	6,132	0	6,132	0	6,132	65.00
66.00	06600	PHYSICAL THERAPY	415,015	0	415,015	0	415,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,150	0	41,150	0	41,150	67.00
68.00	06800	SPEECH PATHOLOGY	2,410	0	2,410	0	2,410	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,543		116,543	0	116,543	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	324,974		324,974	0	324,974	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	871,623		871,623	0	871,623	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
91.00	09100	EMERGENCY	3,106,795		3,106,795	0	3,106,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	702,027		702,027		702,027	92.00
200.00		Subtotal (see instructions)	14,279,374	0	14,279,374	0	14,279,374	200.00
201.00		Less Observation Beds	702,027		702,027		702,027	201.00
202.00		Total (see instructions)	13,577,347	0	13,577,347	0	13,577,347	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 12:32 pm

Title XIX | Hospital | PPS

		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	1,964,505		1,964,505			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,137	5,310,728	5,359,865	0.262070	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	307,246	16,245,777	16,553,023	0.180349	0.000000	54.00
60.00	06000	LABORATORY	531,120	9,549,111	10,080,231	0.166265	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	167,505	51,846	219,351	0.027955	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	248,810	1,041,969	1,290,779	0.321523	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	69,108	108,028	177,136	0.232307	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,335	4,775	7,110	0.338959	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	456,001	715,725	1,171,726	0.099463	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	564	375,828	376,392	0.863392	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	903,500	1,795,536	2,699,036	0.322939	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
91.00	09100	EMERGENCY	6,886	12,924,653	12,931,539	0.240249	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,368	1,691,620	1,698,988	0.413203	0.000000	92.00
200.00		Subtotal (see instructions)	4,714,085	49,815,596	54,529,681			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,714,085	49,815,596	54,529,681			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 12:32 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.262070	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.180349	54.00
60.00	06000	LABORATORY	0.166265	60.00
65.00	06500	RESPIRATORY THERAPY	0.027955	65.00
66.00	06600	PHYSICAL THERAPY	0.321523	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.232307	67.00
68.00	06800	SPEECH PATHOLOGY	0.338959	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.099463	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.863392	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322939	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
91.00	09100	EMERGENCY	0.240249	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.413203	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part II Date/Time Prepared: 11/21/2014 12:32 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,404,661	169,390	1,235,271	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,985,317	637,995	2,347,322	0	0	54.00
60.00	06000	LABORATORY	1,675,989	55,946	1,620,043	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,132	341	5,791	0	0	65.00
66.00	06600	PHYSICAL THERAPY	415,015	22,684	392,331	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,150	1,022	40,128	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,410	58	2,352	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,543	7,464	109,079	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	324,974	10,580	314,394	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	871,623	80,550	791,073	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	3,106,795	123,382	2,983,413	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	702,027	70,852	631,175	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	11,652,636	1,180,264	10,472,372	0	0	200.00
201.00		Less Observation Beds	702,027	70,852	631,175	0	0	201.00
202.00		Total (line 200 minus line 201)	10,950,609	1,109,412	9,841,197	0	0	202.00

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

Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part II Date/Time Prepared: 11/21/2014 12:32 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,404,661	5,359,865	0.262070		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,985,317	16,553,023	0.180349		54.00
60.00	06000	LABORATORY	1,675,989	10,080,231	0.166265		60.00
65.00	06500	RESPIRATORY THERAPY	6,132	219,351	0.027955		65.00
66.00	06600	PHYSICAL THERAPY	415,015	1,290,779	0.321523		66.00
67.00	06700	OCCUPATIONAL THERAPY	41,150	177,136	0.232307		67.00
68.00	06800	SPEECH PATHOLOGY	2,410	7,110	0.338959		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,543	1,171,726	0.099463		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	324,974	376,392	0.863392		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	871,623	2,699,036	0.322939		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000		88.00
91.00	09100	EMERGENCY	3,106,795	12,931,539	0.240249		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	702,027	1,698,988	0.413203		92.00
200.00		Subtotal (sum of lines 50 thru 199)	11,652,636	52,565,176			200.00
201.00		Less Observation Beds	702,027	0			201.00
202.00		Total (line 200 minus line 201)	10,950,609	52,565,176			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/21/2014 12:32 pm

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	169,390	5,359,865	0.031603	26,622	841	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	637,995	16,553,023	0.038543	116,320	4,483	54.00
60.00	06000	LABORATORY	55,946	10,080,231	0.005550	417,956	2,320	60.00
65.00	06500	RESPIRATORY THERAPY	341	219,351	0.001555	93,039	145	65.00
66.00	06600	PHYSICAL THERAPY	22,684	1,290,779	0.017574	64,799	1,139	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,022	177,136	0.005770	16,542	95	67.00
68.00	06800	SPEECH PATHOLOGY	58	7,110	0.008158	1,080	9	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,464	1,171,726	0.006370	164,850	1,050	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	10,580	376,392	0.028109	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,550	2,699,036	0.029844	462,349	13,798	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
91.00	09100	EMERGENCY	123,382	12,931,539	0.009541	6,406	61	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	70,852	1,698,988	0.041702	6,968	291	92.00
200.00		Total (lines 50-199)	1,180,264	52,565,176		1,376,931	24,232	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/21/2014 12:32 pm

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
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/21/2014 12:32 pm

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	5,359,865	0.000000	0.000000	26,622	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	16,553,023	0.000000	0.000000	116,320	54.00
60.00	06000	LABORATORY	0	10,080,231	0.000000	0.000000	417,956	60.00
65.00	06500	RESPIRATORY THERAPY	0	219,351	0.000000	0.000000	93,039	65.00
66.00	06600	PHYSICAL THERAPY	0	1,290,779	0.000000	0.000000	64,799	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	177,136	0.000000	0.000000	16,542	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,110	0.000000	0.000000	1,080	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,171,726	0.000000	0.000000	164,850	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	376,392	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,699,036	0.000000	0.000000	462,349	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	12,931,539	0.000000	0.000000	6,406	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,698,988	0.000000	0.000000	6,968	92.00
200.00		Total (lines 50-199)	0	52,565,176			1,376,931	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/21/2014 12:32 pm

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
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/21/2014 12:32 pm

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	0.262070	0	1,797,892	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.180349	0	3,857,612	0	0	54.00
60.00	06000	LABORATORY	0.166265	0	3,735,824	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.027955	0	34,080	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.321523	0	276,086	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.232307	0	23,746	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.338959	0	1,458	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.099463	0	296,239	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.863392	0	236,805	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322939	0	872,062	8,576	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.240249	0	2,960,527	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.413203	0	352,872	0	0	92.00
200.00		Subtotal (see instructions)		0	14,445,203	8,576	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	14,445,203	8,576	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/21/2014 12:32 pm

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	471,174	0		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	695,716	0		54.00
60.00	06000	LABORATORY	621,137	0		60.00
65.00	06500	RESPIRATORY THERAPY	953	0		65.00
66.00	06600	PHYSICAL THERAPY	88,768	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,516	0		67.00
68.00	06800	SPEECH PATHOLOGY	494	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,465	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	204,456	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	281,623	2,770		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	711,264	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	145,808	0		92.00
200.00		Subtotal (see instructions)	3,256,374	2,770		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,256,374	2,770		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151303 | Component CCN: 15Z303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V | Date/Time Prepared: 11/21/2014 12:32 pm

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	0.262070	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.180349	0	0	0	0	54.00
60.00	06000	LABORATORY	0.166265	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.027955	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.321523	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.232307	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.338959	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.099463	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.863392	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322939	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.240249	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.413203	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: 151303 | Component CCN: 15Z303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V | Date/Time Prepared: 11/21/2014 12:32 pm

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
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part I Date/Time Prepared: 11/21/2014 12:32 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	209,614	43,516	166,098	1,710	97.13	30.00
200.00	Total (lines 30-199)	209,614		166,098	1,710		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	76	7,382	30.00
200.00	Total (lines 30-199)	76	7,382	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/21/2014 12:32 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	169,390	5,359,865	0.031603	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	637,995	16,553,023	0.038543	21,029	811	54.00
60.00	06000	LABORATORY	55,946	10,080,231	0.005550	50,427	280	60.00
65.00	06500	RESPIRATORY THERAPY	341	219,351	0.001555	0	0	65.00
66.00	06600	PHYSICAL THERAPY	22,684	1,290,779	0.017574	724	13	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,022	177,136	0.005770	284	2	67.00
68.00	06800	SPEECH PATHOLOGY	58	7,110	0.008158	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,464	1,171,726	0.006370	25,070	160	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	10,580	376,392	0.028109	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,550	2,699,036	0.029844	123,541	3,687	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
91.00	09100	EMERGENCY	123,382	12,931,539	0.009541	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	70,852	1,698,988	0.041702	0	0	92.00
200.00		Total (lines 50-199)	1,180,264	52,565,176		221,075	4,953	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part III Date/Time Prepared: 11/21/2014 12:32 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,710	0.00	76	0		30.00
200.00		Total (lines 30-199)	1,710		76	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/21/2014 12:32 pm

Title XIX | Hospital | PPS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/21/2014 12:32 pm

Title XIX | Hospital | PPS

		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	5,359,865	0.000000	0.000000	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	16,553,023	0.000000	0.000000	21,029	54.00
60.00	06000	LABORATORY	0	10,080,231	0.000000	0.000000	50,427	60.00
65.00	06500	RESPIRATORY THERAPY	0	219,351	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,290,779	0.000000	0.000000	724	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	177,136	0.000000	0.000000	284	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,110	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,171,726	0.000000	0.000000	25,070	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	376,392	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,699,036	0.000000	0.000000	123,541	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	12,931,539	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,698,988	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	52,565,176			221,075	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/21/2014 12:32 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 12:32 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,203	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,710	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,132	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	224	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)	224	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	23	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)	22	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	701	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)	224	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)	224	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	126.36	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	126.36	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,626,738	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)	2,906	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)	2,780	25.00
26.00	Total swing-bed cost (see instructions)	549,813	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,076,925	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,076,925	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)	1,214.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	851,414	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)	851,414	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 12:32 pm

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)						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)	295,215	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,146,629	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)	272,064	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	272,064	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	544,128	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)	578	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,214.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	702,027	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 12:32 pm

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	209,614	2,076,925	0.100925	702,027	70,852	90.00
91.00	Nursing School cost	0	2,076,925	0.000000	702,027	0	91.00
92.00	Allied health cost	0	2,076,925	0.000000	702,027	0	92.00
93.00	All other Medical Education	0	2,076,925	0.000000	702,027	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 12:32 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,203	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,710	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,132	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	448	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	23	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)	22	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	76	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,626,738	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	545,310	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,081,428	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,081,428	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)	1,217.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	92,508	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)	92,508	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 12:32 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	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)	54,866	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	147,374	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)	7,382	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	4,953	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	12,335	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	135,039	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	578	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,217.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	703,547	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 12:32 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	209,614	2,081,428	0.100707	703,547	70,852	90.00
91.00	Nursing School cost	0	2,081,428	0.000000	703,547	0	91.00
92.00	Allied health cost	0	2,081,428	0.000000	703,547	0	92.00
93.00	All other Medical Education	0	2,081,428	0.000000	703,547	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/21/2014 12:32 pm

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		769,924		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.262070	26,622	6,977	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.180349	116,320	20,978	54.00
60.00	06000	LABORATORY	0.166265	417,956	69,491	60.00
65.00	06500	RESPIRATORY THERAPY	0.027955	93,039	2,601	65.00
66.00	06600	PHYSICAL THERAPY	0.321523	64,799	20,834	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.232307	16,542	3,843	67.00
68.00	06800	SPEECH PATHOLOGY	0.338959	1,080	366	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.099463	164,850	16,396	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.863392	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322939	462,349	149,311	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.240249	6,406	1,539	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.413203	6,968	2,879	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,376,931	295,215	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)		1,376,931		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151303 | Component CCN: 15Z303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/21/2014 12:32 pm

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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.262070	1,434	376	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.180349	22,925	4,135	54.00
60.00	06000	LABORATORY	0.166265	62,737	10,431	60.00
65.00	06500	RESPIRATORY THERAPY	0.027955	25,962	726	65.00
66.00	06600	PHYSICAL THERAPY	0.321523	162,800	52,344	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.232307	47,033	10,926	67.00
68.00	06800	SPEECH PATHOLOGY	0.338959	895	303	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.099463	83,023	8,258	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.863392	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322939	121,372	39,196	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.240249	480	115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.413203	400	165	92.00
200.00		Total (sum of lines 50-94 and 96-98)		529,061	126,975	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)		529,061		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/21/2014 12:32 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		276,076		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.262070	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.180349	21,029	3,793	54.00
60.00	06000	LABORATORY	0.166265	50,427	8,384	60.00
65.00	06500	RESPIRATORY THERAPY	0.027955	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.321523	724	233	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.232307	284	66	67.00
68.00	06800	SPEECH PATHOLOGY	0.338959	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.099463	25,070	2,494	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.863392	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322939	123,541	39,896	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
91.00	09100	EMERGENCY	0.240249	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.413203	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		221,075	54,866	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		221,075		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151303	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/21/2014 12:32 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,259,144	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)	3,259,144	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)	3,291,735	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)	23,088	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,231,099	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)	1,037,548	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)	1,037,548	30.00
31.00	Primary payer payments	463	31.00
32.00	Subtotal (line 30 minus line 31)	1,037,085	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)	651,626	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	573,431	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	466,080	36.00
37.00	Subtotal (see instructions)	1,610,516	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)	1,610,516	40.00
40.01	Sequestration adjustment (see instructions)	32,210	40.01
41.00	Interim payments	1,726,001	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-147,695	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: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2014 12:32 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,173,108		1,675,201	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	09/09/2013	50,800	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		50,800	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)		1,173,108		1,726,001	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		212,643		147,695	6.02
7.00	Total Medicare program liability (see instructions)		960,465		1,578,306	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151303 | Component CCN: 15Z303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2014 12:32 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		787,908		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		787,908		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		142,110		0	6.02
7.00	Total Medicare program liability (see instructions)		645,798		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151303 Component CCN: 15Z303	Period: From 07/01/2013 To 06/30/2014	Worksheet E-2 Date/Time Prepared: 11/21/2014 12:32 pm
	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)	549,569	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)	128,245	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	448	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)	677,814	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	677,814	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)	677,814	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	21,664	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)	656,150	0	15.00
16.00		0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
17.00	Allowable bad debts (see instructions)	3,214	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	2,828	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,214	0	18.00
19.00	Total (see instructions)	658,978	0	19.00
19.01	Sequestration adjustment (see instructions)	13,180	0	19.01
20.00	Interim payments	787,908	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	-142,110	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151303	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part V Date/Time Prepared: 11/21/2014 12:32 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,146,629	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	1,146,629	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,158,095	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,158,095	19.00
20.00	Deductibles (exclude professional component)	199,008	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	959,087	22.00
23.00	Coinsurance	608	23.00
24.00	Subtotal (line 22 minus line 23)	958,479	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	24,531	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	21,587	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	8,998	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	980,066	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)	980,066	30.00
30.01	Sequestration adjustment (see instructions)	19,601	30.01
31.00	Interim payments	1,173,108	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	-212,643	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G | Date/Time Prepared: 11/21/2014 12:32 pm

		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	7,187,185	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,835,143	0	0	0	4.00
5.00	Other receivable	4,319	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,073,528	0	0	0	6.00
7.00	Inventory	223,919	0	0	0	7.00
8.00	Prepaid expenses	149,836	0	0	0	8.00
9.00	Other current assets	961,291	0	0	0	9.00
10.00	Due from other funds	-185,899	185,899	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,102,266	185,899	0	0	11.00
	FIXED ASSETS					
12.00	Land	127,944	0	0	0	12.00
13.00	Land improvements	409,779	0	0	0	13.00
14.00	Accumulated depreciation	-386,888	0	0	0	14.00
15.00	Buildings	13,701,092	0	0	0	15.00
16.00	Accumulated depreciation	-5,458,949	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	968,285	0	0	0	19.00
20.00	Accumulated depreciation	-882,028	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	3,400,066	0	0	0	23.00
24.00	Accumulated depreciation	-3,050,322	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)	8,828,979	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	340,717	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	340,717	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	20,271,962	185,899	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,370,255	0	0	0	37.00
38.00	Salaries, wages, and fees payable	330,041	0	0	0	38.00
39.00	Payroll taxes payable	36,586	0	0	0	39.00
40.00	Notes and loans payable (short term)	151,903	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	1,422,385	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,311,170	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,491,178	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	100,169	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	10,591,347	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	13,902,517	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	6,369,445				52.00
53.00	Specific purpose fund		185,899			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)	6,369,445	185,899	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	20,271,962	185,899	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-1 | Date/Time Prepared: 11/21/2014 12:32 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		4,082,159		177,410		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,134,229				2.00
3.00	Total (sum of line 1 and line 2)		7,216,388		177,410		3.00
4.00	RESTRICTED CONTR. USED FOR PROPERTY	0		0		0	4.00
5.00	DEFERRED PENSION COSTS	0		0		0	5.00
6.00	GRANT REVENUE	0		0		0	6.00
7.00	ROUNDING	3		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		3		0		10.00
11.00	Subtotal (line 3 plus line 10)		7,216,391		177,410		11.00
12.00	TRANSFERS TO AFFILIATES	0		0		0	12.00
13.00	TEMP RESTRICTED - RELEASED CAPITAL	0		0		0	13.00
14.00	TEMP RESTRICTED - RELEASED OPERATING	0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		7,216,391		177,410		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	RESTRICTED CONTR. USED FOR PROPERTY		0			4.00
5.00	DEFERRED PENSION COSTS		0			5.00
6.00	GRANT REVENUE		0			6.00
7.00	ROUNDING		0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	TRANSFERS TO AFFILIATES		0			12.00
13.00	TEMP RESTRICTED - RELEASED CAPITAL		0			13.00
14.00	TEMP RESTRICTED - RELEASED OPERATING		0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 151303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/21/2014 12:32 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,367,924		2,367,924	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)	2,367,924		2,367,924	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)	2,367,924		2,367,924	17.00
18.00	Ancillary services	2,433,328	35,313,450	37,746,778	18.00
19.00	Outpatient services	0	14,774,442	14,774,442	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	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,801,252	50,087,892	54,889,144	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		15,830,189		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00		0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		15,830,189		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151303	Period: From 07/01/2013 To 06/30/2014	Worksheet G-3 Date/Time Prepared: 11/21/2014 12:32 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	54,889,144	1.00
2.00	Less contractual allowances and discounts on patients' accounts	37,343,754	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,545,390	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,830,189	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,715,201	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	309,882	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	44,093	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	9,593	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	1,244	21.00
22.00	Rental of hospital space	351,179	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANTS	3,423	24.00
24.01	UNREALIZED GAINS / LOSSES	546,182	24.01
24.02	OTHER MISC INCOME	8,417	24.02
24.03	PHARMACY EMP	65,353	24.03
24.04	NONRECURRING EXPENSE	25,233	24.04
24.05	OPER. NET ASSETS RELEASED FROM RESTR	54,429	24.05
24.06		0	24.06
25.00	Total other income (sum of lines 6-24)	1,419,028	25.00
26.00	Total (line 5 plus line 25)	3,134,229	26.00
27.00		0	27.00
27.01	ROUNDING	0	27.01
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)	3,134,229	29.00

Allocation of Physician Compensation: Hours **Provider:** ST. VINCENT JENNINGS HOSPITAL
Department: MEDICAL AFFAIRS **Number:** 151303
Physician: AGGREGATE MEDICAL / SURGERY PHYSICIANS **Specialty:** INTERNAL MEDICINE-GENERAL

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

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

Signature: Physician or Physician Department Head Date v7

Allocation of Physician Compensation: Hours
Department: RADIOLOGY
Physician: AGGREGATE RADIOLOGY

Provider: ST. VINCENT JENNINGS HOSPITAL
Number: 151303
Specialty: RADIOLOGY-GENERAL

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

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

Signature: Physician or Physician Department Head Date

v7

Allocation of Physician Compensation: Hours
Department: LABORATORY
Physician: AGGREGATE LABORATORY

Provider: ST. VINCENT JENNINGS HOSPITAL
Number: 151303
Specialty: INTERNAL MEDICINE-GENERAL

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

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

Signature: Physician or Physician Department Head Date v7

Allocation of Physician Compensation: Hours

Department: EMERGENCY DEPARTMENT

Physician: AGGREGATE EMERGENCY ROOM PHYSICIANS

Provider: ST. VINCENT JENNINGS HOSPITAL

Number: 151303

Specialty: EMERGENCY MEDICINE-GENERAL

Basis of Allocation: Time Study

Describe:

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Heath Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	6016.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	6016.00
2. Physician Services: Medical and Surgical Services to Individual Patients.	2744.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	8760.00
5. Professional Component Percentage (Line 2 / Line 4)	31.32 %
6. Provider Component Percentage (Line 1D / Line 4)	68.68 %

Signature: Physician or Physician Department Head

Date

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