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 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/23/2015 3:43 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/23/2015 Time: 3:43 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 07/01/2014 and ending 06/30/2015 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	198,180	210,558	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	72,343	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	270,523	210,558	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 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/23/2015 8:22 am

	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2014	06/30/2015	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)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period 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) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
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 column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 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 column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 8:22 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the 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
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		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 Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. 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 Wkst. D, Parts III & IV and D-2, Pt. 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, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. 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 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 8:22 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	

	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider 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 nonprovider 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 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 8:22 am

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider 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. (see 42 CFR 412.424(d)(1)(iii)(c)) 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, indicate which program year began during this cost reporting period. (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, indicate which program year began during this cost reporting period. (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
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	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
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		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/IID 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

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	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	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 is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	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	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		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 column 1 is 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 hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §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:	36,123	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 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 8:22 am

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00
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, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
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 (see instructions)						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 §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
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
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 COMPLEX IDENTIFICATION DATA	Provider CCN: 151303	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 8:22 am

		1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)	N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/23/2015 8:22 am

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

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

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program 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	10/13/2015	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 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 11/23/2015 8:22 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				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 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/23/2015 8:22 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	10/13/2015			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 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/23/2015 8:22 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	21,936.00	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	21,936.00	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	21,936.00	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 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/23/2015 8:22 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	528	70	914			1.00
2.00	HMO and other (see instructions)	112	48				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	250	0	250			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	10			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	778	70	1,174			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)	778	70	1,174	0.00	90.32	14.00
15.00	CAH visits	8,719	2,353	30,084			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	90.32	27.00
28.00	Observation Bed Days		0	589			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/23/2015 8:22 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	170	26	339	1.00
2.00	HMO and other (see instructions)			34	21		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		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	170	26	339	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 07/01/2014 To 06/30/2015 | Worksheet S-10 | Date/Time Prepared: 11/23/2015 8:22 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.248389	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	64,150	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	11,999,032	6.00
7.00	Medicaid cost (line 1 times line 6)	2,980,428	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)	2,916,278	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	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,916,278	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	3,810,635	230,954	4,041,589	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	946,520	57,366	1,003,886	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)	946,520	57,366	1,003,886	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)	3,147,002	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	656,690	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,490,312	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	618,566	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,622,452	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,538,730	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/23/2015 8:22 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		731,636	731,636	-15,648	715,988	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	307,239	1,598,633	1,905,872	0	1,905,872	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,181,516	1,416,646	2,598,162	15,648	2,613,810	5.00
7.00	00700	OPERATION OF PLANT	53,726	875,039	928,765	0	928,765	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	27,741	27,741	0	27,741	8.00
9.00	00900	HOUSEKEEPING	0	329,324	329,324	0	329,324	9.00
10.00	01000	DIETARY	0	259,222	259,222	-58,137	201,085	10.00
11.00	01100	CAFETERIA	0	0	0	58,137	58,137	11.00
13.00	01300	NURSING ADMINISTRATION	70,778	123,111	193,889	0	193,889	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	74,751	14,795	89,546	0	89,546	14.00
15.00	01500	PHARMACY	167,656	391,535	559,191	0	559,191	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	127,245	25,875	153,120	0	153,120	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	885,017	378,374	1,263,391	-14,432	1,248,959	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	337,365	441,414	778,779	-53,913	724,866	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	791,847	871,084	1,662,931	0	1,662,931	54.00
60.00	06000	LABORATORY	0	1,193,553	1,193,553	0	1,193,553	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,253	5,253	0	5,253	65.00
66.00	06600	PHYSICAL THERAPY	299	226,967	227,266	-1,589	225,677	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,115	9,115	0	9,115	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,869	1,869	0	1,869	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,730	4,730	113,417	118,147	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	48,898	48,898	0	48,898	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	849,465	894,461	1,743,926	-43,483	1,700,443	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,846,904	9,869,275	14,716,179	0	14,716,179	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	37,779	37,779	0	37,779	194.00
194.02	07952	OUTPATIENT CLINICS	0	1,376	1,376	0	1,376	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)	4,846,904	9,908,430	14,755,334	0	14,755,334	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/23/2015 8:22 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-267,977	448,011		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-73,528	1,832,344		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	871,335	3,485,145		5.00
7.00	00700	OPERATION OF PLANT	-32,270	896,495		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	27,741		8.00
9.00	00900	HOUSEKEEPING	-16,466	312,858		9.00
10.00	01000	DIETARY	-58	201,027		10.00
11.00	01100	CAFETERIA	-85,666	-27,529		11.00
13.00	01300	NURSING ADMINISTRATION	0	193,889		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	89,546		14.00
15.00	01500	PHARMACY	-2,343	556,848		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-10,769	142,351		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-173,477	1,075,482		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	724,866		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-117,649	1,545,282		54.00
60.00	06000	LABORATORY	-4,493	1,189,060		60.00
65.00	06500	RESPIRATORY THERAPY	0	5,253		65.00
66.00	06600	PHYSICAL THERAPY	0	225,677		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,115		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,869		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	118,147		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	48,898		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	-150,000	1,550,443		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-63,361	14,652,818		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	37,779		194.00
194.02	07952	OUTPATIENT CLINICS	0	1,376		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	89,291	89,291		194.03
194.04	07955	SPN	0	0		194.04
200.00		TOTAL (SUM OF LINES 118-199)	25,930	14,781,264		200.00

RECLASSIFICATIONS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/23/2015 8:22 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	0	58,137		1.00
	TOTALS		0	58,137		
	B - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,648		1.00
	TOTALS		0	15,648		
	C - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	113,417		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
	TOTALS		0	113,417		
500.00	Grand Total: Increases		0	187,202		500.00

RECLASSIFICATIONS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/23/2015 8:22 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	0	58,137	0		1.00
	TOTALS		0	58,137			
	B - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	15,648	9		1.00
	TOTALS		0	15,648			
	C - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	14,432	0		1.00
2.00	OPERATING ROOM	50.00	0	53,913	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	1,589	0		3.00
4.00	EMERGENCY	91.00	0	43,483	0		4.00
	TOTALS		0	113,417			
500.00	Grand Total: Decreases		0	187,202			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 11/23/2015 8:22 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	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	13,701,092	0	0	0	19,551	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	968,285	98,132	0	98,132	0	5.00
6.00	Movable Equipment	3,400,066	475,341	0	475,341	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,607,166	573,473	0	573,473	19,551	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	18,607,166	573,473	0	573,473	19,551	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	13,681,541	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,066,417	0	5.00
6.00	Movable Equipment	3,875,407	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,161,088	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	19,161,088	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 11/23/2015 8:22 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	376,267	0	330,960	24,409	0	1.00
3.00	Total (sum of lines 1-2)	376,267	0	330,960	24,409	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	731,636		1.00
3.00	Total (sum of lines 1-2)	0	731,636		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 11/23/2015 8:22 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	19,161,088	0	19,161,088	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	19,161,088	0	19,161,088	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	160,927	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	160,927	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	262,675	24,409	0	0	448,011	1.00
3.00	Total (sum of lines 1-2)	262,675	24,409	0	0	448,011	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/23/2015 8:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-199,692	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	-9,910	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	-4,484	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	-440,236			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,061,620			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-85,666	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	-10,769	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** 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	PAYROLL INCENTIVE	A	-152,891	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISC REVENUE	B	-952	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/23/2015 8:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	CHARITABLE EXPENSE	A	-5,317	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	AHA & IHA DUES	A	-554	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.07	MISC REVENUE	B	-2,343	PHARMACY	15.00	0	33.07
33.08	MISC REVENUE	B	-4,493	LABORATORY	60.00	0	33.08
33.09	PHYSICIAN HOUSEKEEPING	A	-16,466	HOUSEKEEPING	9.00	0	33.09
33.10	PHYSICIAN PLANT OPS	A	-11,149	OPERATION OF PLANT	7.00	0	33.10
33.11	PHYSICIAN BENEFITS	A	-254	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	MISC REVENUE	B	-58	DIETARY	10.00	0	33.12
33.13	MISC REVENUE	B	-2,439	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	ENTERTAINMENT	A	-231	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	ENTERTAINMENT	A	-325	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	ENTERTAINMENT	A	-171	RADIOLOGY - DIAGNOSTIC	54.00	0	33.16
33.17	HOSPITAL PROVIDER TAX	A	-86,571	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	LATE PENALTY FEE	A	-27	ADULTS & PEDIATRICS	30.00	0	33.18
33.19	LATE PENALTY FEE	A	-692	RADIOLOGY - DIAGNOSTIC	54.00	0	33.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		25,930				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 07/01/2014 To 06/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 11/23/2015 8:22 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	69,780	69,780	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,911,401	930,609	2.00
3.00	194.03	OTHER NONREIMBURSABLE COST C	HOME OFFICE	89,291	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	133,461	133,461	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACKS	618,599	618,599	4.01
4.02	7.00	OPERATION OF PLANT	SVH CHARGEBACKS	25,664	25,664	4.02
4.03	13.00	NURSING ADMINISTRATION	SVH CHARGEBACKS	350	350	4.03
4.04	14.00	CENTRAL SERVICES & SUPPLY	SVH CHARGEBACKS	84,103	84,103	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACKS	60,843	60,843	4.05
4.06	0.00			0	0	4.06
4.07	54.00	RADIOLOGY - DIAGNOSTIC	SVH CHARGEBACKS	22,134	22,134	4.07
4.08	0.00			0	0	4.08
4.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE SELF-INSURANCE	774,720	841,823	4.09
4.10	0.00			0	0	4.10
4.11	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	247,027	315,312	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	12,259	15,648	4.12
4.13	0.00			0	0	4.13
4.14	7.00	OPERATION OF PLANT	TRIMEDX	416,683	433,320	4.14
4.15	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	208,139	61,188	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	4,674,454	3,612,834	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 07/01/2014 To 06/30/2015	Worksheet A-8-1 Date/Time Prepared: 11/23/2015 8:22 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	980,792	0		2.00
3.00	89,291	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	-67,103	0		4.09
4.10	0	0		4.10
4.11	-68,285	11		4.11
4.12	-3,389	0		4.12
4.13	0	0		4.13
4.14	-16,637	0		4.14
4.15	146,951	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	1,061,620			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 07/01/2014 To 06/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 11/23/2015 8:22 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	173,450	173,450	0	0	0	1.00
2.00	54.00	RADIOLOGY - DIAGNOSTIC	116,786	116,786	0	0	0	2.00
3.00	91.00	EMERGENCY	597,235	150,000	447,235	0	0	3.00
4.00	0.00		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			887,471	440,236	447,235		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	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		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	173,450		1.00
2.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	116,786		2.00
3.00	91.00	EMERGENCY	0	0	0	150,000		3.00
4.00	0.00		0	0	0	0		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	440,236		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/23/2015 8:22 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					293	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)					59	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	1,704.00	1,304.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.54	58.15	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)	38.77	38.77	29.08			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)					132,128	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					75,828	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					207,956	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)					207,956	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)					207,956	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)					11,360	24.00
25.00	Assistants (line 4 times column 3, line 11)					1,716	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					13,076	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)					1,834	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					14,910	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)					14,910	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 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/23/2015 8:22 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.54	58.15	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)	207,956		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	14,910		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)	222,866		63.00
64.00	Total cost of outside supplier services (from your records)	219,417		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	13,076		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,834		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	14,910		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	1,834		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	1,834		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 07/01/2014 To 06/30/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/23/2015 8:22 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		21	1.00
2.00	Line 1 multiplied by 15 hours per week		315	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		30	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	83.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.50	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)	36.75	36.75	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)	6,101	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)	6,101	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)	6,101	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)	73.51	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	23,156	22.00
23.00	Total salary equivalency (see instructions)	23,156	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)	1,103	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)	1,103	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)	156	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	1,259	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)	1,259	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 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/23/2015 8:22 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.50	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)	23,156	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	1,259	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)	24,415	63.00
64.00	Total cost of outside supplier services (from your records)	9,053	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	1,103	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	156	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	1,259	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	156	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	156	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 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/23/2015 8:22 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					18	1.00
2.00	Line 1 multiplied by 15 hours per week					270	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					20	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	36.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	70.65	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)	35.33	35.33	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)					2,543	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)					2,543	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)					2,543	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)					70.64	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					19,073	22.00
23.00	Total salary equivalency (see instructions)					19,073	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)					707	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)					707	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)					104	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					811	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)					811	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 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/23/2015 8:22 am

		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)	70.65	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)	19,073	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	811	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)	19,884	63.00
64.00	Total cost of outside supplier services (from your records)	1,869	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	707	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	104	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	811	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	104	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	104	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 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/23/2015 8:22 am

		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	448,011	448,011				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,832,344	0	1,832,344			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,485,145	39,579	476,894	4,001,618	4,001,618	5.00
7.00	00700	OPERATION OF PLANT	896,495	40,898	21,685	959,078	355,430	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,741	487	0	28,228	10,461	8.00
9.00	00900	HOUSEKEEPING	312,858	9,195	0	322,053	119,351	9.00
10.00	01000	DIETARY	201,027	4,534	0	205,561	76,180	10.00
11.00	01100	CAFETERIA	-27,529	9,343	0	-18,186	0	11.00
13.00	01300	NURSING ADMINISTRATION	193,889	1,063	28,568	223,520	82,835	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	89,546	7,454	30,172	127,172	47,129	14.00
15.00	01500	PHARMACY	556,848	4,194	67,671	628,713	232,998	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	142,351	35,481	51,360	229,192	84,937	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,075,482	42,032	357,219	1,474,733	546,529	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	724,866	33,400	136,171	894,437	331,474	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,545,282	27,067	319,613	1,891,962	701,152	54.00
60.00	06000	LABORATORY	1,189,060	11,289	0	1,200,349	444,843	60.00
65.00	06500	RESPIRATORY THERAPY	5,253	0	0	5,253	1,947	65.00
66.00	06600	PHYSICAL THERAPY	225,677	58,475	121	284,273	105,350	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,115	0	0	9,115	3,378	67.00
68.00	06800	SPEECH PATHOLOGY	1,869	0	0	1,869	693	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	118,147	0	0	118,147	43,785	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	48,898	0	0	48,898	18,121	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	1,550,443	27,035	342,870	1,920,348	711,666	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)	14,652,818	351,526	1,832,344	14,556,333	3,918,259	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,318	0	2,318	859	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,065	0	5,065	1,877	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	37,779	0	0	37,779	14,001	194.00
194.02	07952	OUTPATIENT CLINICS	1,376	0	0	1,376	510	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	89,291	0	0	89,291	33,091	194.03
194.04	07955	SPN	0	89,102	0	89,102	33,021	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)	14,781,264	448,011	1,832,344	14,781,264	4,001,618	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/23/2015 8:22 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,314,508					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,741	40,430				8.00
9.00	00900	HOUSEKEEPING	32,887	0	474,291			9.00
10.00	01000	DIETARY	16,215	0	10,804	308,760		10.00
11.00	01100	CAFETERIA	33,414	0	0	0	15,228	11.00
13.00	01300	NURSING ADMINISTRATION	3,802	0	0	0	235	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26,658	0	0	0	480	14.00
15.00	01500	PHARMACY	15,001	0	10,334	0	533	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	126,900	0	0	0	785	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	150,329	6,452	96,549	308,760	3,982	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	119,457	25,756	50,840	0	1,782	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	96,807	5,266	31,292	0	3,417	54.00
60.00	06000	LABORATORY	40,376	0	11,382	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	209,141	690	8,238	0	1	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	96,692	757	100,632	0	4,013	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	969,420	38,921	320,071	308,760	15,228	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	8,291	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,116	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	1,879	0	0	194.00
194.02	07952	OUTPATIENT CLINICS	0	1,509	43,397	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07955	SPN	318,681	0	108,944	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)	1,314,508	40,430	474,291	308,760	15,228	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/23/2015 8:22 am

		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	310,392					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	201,439				14.00
15.00	01500	PHARMACY	0	0	887,579			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	441,814		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,652	11,584	0	23,189	2,706,759	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	84,652	43,276	0	50,529	1,602,203	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	134,621	2,864,517	54.00
60.00	06000	LABORATORY	0	0	0	92,836	1,789,786	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,718	8,918	65.00
66.00	06600	PHYSICAL THERAPY	0	1,276	0	9,932	618,901	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	325	12,818	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	74	2,636	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	77,322	0	0	239,254	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	33,077	0	0	100,096	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	887,579	0	887,579	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	141,088	34,904	0	128,590	3,138,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	310,392	201,439	887,579	441,814	13,972,157	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	11,468	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	25,058	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	53,659	194.00
194.02	07952	OUTPATIENT CLINICS	0	0	0	0	46,792	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	122,382	194.03
194.04	07955	SPN	0	0	0	0	549,748	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)	310,392	201,439	887,579	441,814	14,781,264	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/23/2015 8:22 am

		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	2,706,759		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,602,203		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	2,864,517		54.00
60.00	06000	LABORATORY	0	1,789,786		60.00
65.00	06500	RESPIRATORY THERAPY	0	8,918		65.00
66.00	06600	PHYSICAL THERAPY	0	618,901		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,818		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,636		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	239,254		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	100,096		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	887,579		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	3,138,690		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	13,972,157		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	11,468		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	25,058		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	53,659		194.00
194.02	07952	OUTPATIENT CLINICS	0	46,792		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	122,382		194.03
194.04	07955	SPN	0	549,748		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	14,781,264		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/23/2015 8:22 am

		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	0	0	0	0		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	214,782	39,579	254,361	0	254,361	5.00
7.00	00700	OPERATION OF PLANT	2,817	40,898	43,715	0	22,593	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	487	487	0	665	8.00
9.00	00900	HOUSEKEEPING	119	9,195	9,314	0	7,587	9.00
10.00	01000	DIETARY	2,072	4,534	6,606	0	4,842	10.00
11.00	01100	CAFETERIA	0	9,343	9,343	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,081	1,063	4,144	0	5,265	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,052	7,454	8,506	0	2,996	14.00
15.00	01500	PHARMACY	25,465	4,194	29,659	0	14,811	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	322	35,481	35,803	0	5,399	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	91,988	42,032	134,020	0	34,740	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	69,411	33,400	102,811	0	21,070	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	422,775	27,067	449,842	0	44,569	54.00
60.00	06000	LABORATORY	0	11,289	11,289	0	28,277	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	124	65.00
66.00	06600	PHYSICAL THERAPY	1,085	58,475	59,560	0	6,697	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	215	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	44	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,842	0	3,842	0	2,783	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	1,152	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	16,115	27,035	43,150	0	45,234	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)	854,926	351,526	1,206,452	0	249,063	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,318	2,318	0	55	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,065	5,065	0	119	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	890	194.00
194.02	07952	OUTPATIENT CLINICS	276	0	276	0	32	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	2,103	194.03
194.04	07955	SPN	0	89,102	89,102	0	2,099	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)	855,202	448,011	1,303,213	0	254,361	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/23/2015 8:22 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	66,308					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	88	1,240				8.00
9.00	00900	HOUSEKEEPING	1,659	0	18,560			9.00
10.00	01000	DIETARY	818	0	423	12,689		10.00
11.00	01100	CAFETERIA	1,686	0	0	0	3,928	11.00
13.00	01300	NURSING ADMINISTRATION	192	0	0	0	61	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,345	0	0	0	124	14.00
15.00	01500	PHARMACY	757	0	404	0	137	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,401	0	0	0	202	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,583	198	3,778	12,689	1,027	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,026	790	1,989	0	460	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	4,883	162	1,225	0	881	54.00
60.00	06000	LABORATORY	2,037	0	445	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	10,550	21	322	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	4,877	23	3,938	0	1,036	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	48,902	1,194	12,524	12,689	3,928	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	418	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	914	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	74	0	0	194.00
194.02	07952	OUTPATIENT CLINICS	0	46	1,698	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07955	SPN	16,074	0	4,264	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	7,101	201.00
202.00		TOTAL (sum lines 118-201)	66,308	1,240	18,560	12,689	11,029	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/23/2015 8:22 am

		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	9,662					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,971				14.00
15.00	01500	PHARMACY	0	0	45,768			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	47,805		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,635	746	0	2,510	199,926	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,635	2,787	0	5,469	144,037	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	14,558	516,120	54.00
60.00	06000	LABORATORY	0	0	0	10,047	52,095	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	186	310	65.00
66.00	06600	PHYSICAL THERAPY	0	82	0	1,075	78,307	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	35	250	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	8	52	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,978	0	0	11,603	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	2,130	0	0	3,282	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	45,768	0	45,768	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	4,392	2,248	0	13,917	118,815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,662	12,971	45,768	47,805	1,170,565	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	2,791	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	6,098	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	964	194.00
194.02	07952	OUTPATIENT CLINICS	0	0	0	0	2,052	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	2,103	194.03
194.04	07955	SPN	0	0	0	0	111,539	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	7,101	201.00
202.00		TOTAL (sum lines 118-201)	9,662	12,971	45,768	47,805	1,303,213	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/23/2015 8:22 am

		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	199,926		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	144,037		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	516,120		54.00
60.00	06000	LABORATORY	0	52,095		60.00
65.00	06500	RESPIRATORY THERAPY	0	310		65.00
66.00	06600	PHYSICAL THERAPY	0	78,307		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	250		67.00
68.00	06800	SPEECH PATHOLOGY	0	52		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,603		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	3,282		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	45,768		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	118,815		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	1,170,565		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,791		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,098		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	964		194.00
194.02	07952	OUTPATIENT CLINICS	0	2,052		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	2,103		194.03
194.04	07955	SPN	0	111,539		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	7,101		201.00
202.00		TOTAL (sum lines 118-201)	0	1,303,213		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/23/2015 8:22 am

		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	4,539,665				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,181	1,181,516	-4,001,618	10,797,832		5.00
7.00	00700	OPERATION OF PLANT	6,387	53,726	0	959,078	57,397	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	76	0	0	28,228	76	8.00
9.00	00900	HOUSEKEEPING	1,436	0	0	322,053	1,436	9.00
10.00	01000	DIETARY	708	0	0	205,561	708	10.00
11.00	01100	CAFETERIA	1,459	0	18,186	0	1,459	11.00
13.00	01300	NURSING ADMINISTRATION	166	70,778	0	223,520	166	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,164	74,751	0	127,172	1,164	14.00
15.00	01500	PHARMACY	655	167,656	0	628,713	655	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,541	127,245	0	229,192	5,541	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,564	885,017	0	1,474,733	6,564	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,216	337,365	0	894,437	5,216	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	4,227	791,847	0	1,891,962	4,227	54.00
60.00	06000	LABORATORY	1,763	0	0	1,200,349	1,763	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,253	0	65.00
66.00	06600	PHYSICAL THERAPY	9,132	299	0	284,273	9,132	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	9,115	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,869	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	118,147	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	48,898	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	849,465	0	1,920,348	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)	54,897	4,539,665	-3,983,432	10,572,901	42,329	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	362	0	0	2,318	362	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	791	0	0	5,065	791	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	37,779	0	194.00
194.02	07952	OUTPATIENT CLINICS	0	0	0	1,376	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	89,291	0	194.03
194.04	07955	SPN	13,915	0	0	89,102	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)	448,011	1,832,344		4,001,618	1,314,508	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.403359	0.403630		0.370595	22.902033	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		0		254,361	66,308	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000000		0.023557	1.155252	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/23/2015 8:22 am

		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	21,726					8.00
9.00	00900	HOUSEKEEPING	0	13,126				9.00
10.00	01000	DIETARY	0	299	100			10.00
11.00	01100	CAFETERIA	0	0	0	126,178		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,944	528	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	3,976	0	14.00
15.00	01500	PHARMACY	0	286	0	4,416	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	6,504	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,467	2,672	100	32,994	144	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,840	1,407	0	14,769	144	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,830	866	0	28,313	0	54.00
60.00	06000	LABORATORY	0	315	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	371	228	0	10	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	407	2,785	0	33,252	240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,915	8,858	100	126,178	528	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	52	0	0	0	194.00
194.02	07952	OUTPATIENT CLINICS	811	1,201	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07955	SPN	0	3,015	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)	40,430	474,291	308,760	15,228	310,392	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.860904	36.133704	3,087.600000	0.120687	587.863636	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,240	18,560	12,689	11,029	9,662	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.057074	1.413988	126.890000	0.031131	18.299242	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/23/2015 8:22 am

		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	297,786				14.00
15.00	01500	PHARMACY	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	51,862,504		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	17,125	0	2,722,055		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	63,974	0	5,931,367		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	15,802,730		54.00
60.00	06000	LABORATORY	0	0	10,897,490		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	201,717		65.00
66.00	06600	PHYSICAL THERAPY	1,886	0	1,165,867		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	38,162		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	8,644		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	114,305	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	48,898	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	51,598	0	15,094,472		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	297,786	100	51,862,504		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	0	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)	201,439	887,579	441,814		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.676456	8,875.790000	0.008519		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,971	45,768	47,805		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.043558	457.680000	0.000922		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,706,759		2,706,759	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,602,203		1,602,203	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,864,517		2,864,517	0	0	54.00
60.00	06000	LABORATORY	1,789,786		1,789,786	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,918	0	8,918	0	0	65.00
66.00	06600	PHYSICAL THERAPY	618,901	0	618,901	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,818	0	12,818	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,636	0	2,636	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	239,254		239,254	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	100,096		100,096	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	887,579		887,579	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
91.00	09100	EMERGENCY	3,138,690		3,138,690	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	909,021		909,021		0	92.00
200.00		Subtotal (see instructions)	14,881,178	0	14,881,178	0	0	200.00
201.00		Less Observation Beds	909,021		909,021		0	201.00
202.00		Total (see instructions)	13,972,157	0	13,972,157	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	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	1,834,181		1,834,181			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,842	5,916,525	5,931,367	0.270124	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	356,312	15,446,418	15,802,730	0.181267	0.000000	54.00
60.00	06000	LABORATORY	545,175	10,352,315	10,897,490	0.164238	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	129,549	72,168	201,717	0.044210	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	152,072	1,013,795	1,165,867	0.530850	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,598	14,564	38,162	0.335884	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,412	6,232	8,644	0.304951	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	207,470	503,315	710,785	0.336605	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	9	255,188	255,197	0.392230	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	879,711	2,542,851	3,422,562	0.259332	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
91.00	09100	EMERGENCY	192,595	14,901,877	15,094,472	0.207936	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	78,068	809,806	887,874	1.023818	0.000000	92.00
200.00		Subtotal (see instructions)	4,415,994	51,835,054	56,251,048			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,415,994	51,835,054	56,251,048			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		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 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/23/2015 8:22 am

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	2,706,759		2,706,759	0	2,706,759	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,602,203		1,602,203	0	1,602,203	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,864,517		2,864,517	0	2,864,517	54.00
60.00	06000	LABORATORY	1,789,786		1,789,786	0	1,789,786	60.00
65.00	06500	RESPIRATORY THERAPY	8,918	0	8,918	0	8,918	65.00
66.00	06600	PHYSICAL THERAPY	618,901	0	618,901	0	618,901	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,818	0	12,818	0	12,818	67.00
68.00	06800	SPEECH PATHOLOGY	2,636	0	2,636	0	2,636	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	239,254		239,254	0	239,254	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	100,096		100,096	0	100,096	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	887,579		887,579	0	887,579	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
91.00	09100	EMERGENCY	3,138,690		3,138,690	0	3,138,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	909,021		909,021		909,021	92.00
200.00		Subtotal (see instructions)	14,881,178	0	14,881,178	0	14,881,178	200.00
201.00		Less Observation Beds	909,021		909,021		909,021	201.00
202.00		Total (see instructions)	13,972,157	0	13,972,157	0	13,972,157	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/23/2015 8:22 am

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	1,834,181		1,834,181			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,842	5,916,525	5,931,367	0.270124	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	356,312	15,446,418	15,802,730	0.181267	0.000000	54.00
60.00	06000	LABORATORY	545,175	10,352,315	10,897,490	0.164238	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	129,549	72,168	201,717	0.044210	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	152,072	1,013,795	1,165,867	0.530850	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,598	14,564	38,162	0.335884	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,412	6,232	8,644	0.304951	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	207,470	503,315	710,785	0.336605	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	9	255,188	255,197	0.392230	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	879,711	2,542,851	3,422,562	0.259332	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	192,595	14,901,877	15,094,472	0.207936	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	78,068	809,806	887,874	1.023818	0.000000	92.00
200.00		Subtotal (see instructions)	4,415,994	51,835,054	56,251,048			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,415,994	51,835,054	56,251,048			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/23/2015 8:22 am

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	0.270124	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.181267	54.00
60.00	06000	LABORATORY	0.164238	60.00
65.00	06500	RESPIRATORY THERAPY	0.044210	65.00
66.00	06600	PHYSICAL THERAPY	0.530850	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.335884	67.00
68.00	06800	SPEECH PATHOLOGY	0.304951	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.336605	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.392230	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.259332	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
91.00	09100	EMERGENCY	0.207936	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.023818	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 07/01/2014 To 06/30/2015 | Worksheet C Part II Date/Time Prepared: 11/23/2015 8:22 am

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	1,602,203	144,037	1,458,166	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,864,517	516,120	2,348,397	0	0	54.00
60.00	06000	LABORATORY	1,789,786	52,095	1,737,691	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,918	310	8,608	0	0	65.00
66.00	06600	PHYSICAL THERAPY	618,901	78,307	540,594	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,818	250	12,568	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,636	52	2,584	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	239,254	11,603	227,651	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	100,096	3,282	96,814	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	887,579	45,768	841,811	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	3,138,690	118,815	3,019,875	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	909,021	78,348	830,673	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	12,174,419	1,048,987	11,125,432	0	0	200.00
201.00		Less Observation Beds	909,021	78,348	830,673	0	0	201.00
202.00		Total (line 200 minus line 201)	11,265,398	970,639	10,294,759	0	0	202.00

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

Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part II Date/Time Prepared: 11/23/2015 8:22 am

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	1,602,203	5,931,367	0.270124		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,864,517	15,802,730	0.181267		54.00
60.00	06000	LABORATORY	1,789,786	10,897,490	0.164238		60.00
65.00	06500	RESPIRATORY THERAPY	8,918	201,717	0.044210		65.00
66.00	06600	PHYSICAL THERAPY	618,901	1,165,867	0.530850		66.00
67.00	06700	OCCUPATIONAL THERAPY	12,818	38,162	0.335884		67.00
68.00	06800	SPEECH PATHOLOGY	2,636	8,644	0.304951		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	239,254	710,785	0.336605		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	100,096	255,197	0.392230		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	887,579	3,422,562	0.259332		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000		88.00
91.00	09100	EMERGENCY	3,138,690	15,094,472	0.207936		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	909,021	887,874	1.023818		92.00
200.00		Subtotal (sum of lines 50 thru 199)	12,174,419	54,416,867			200.00
201.00		Less Observation Beds	909,021	0			201.00
202.00		Total (line 200 minus line 201)	11,265,398	54,416,867			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	144,037	5,931,367	0.024284	14,842	360	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	516,120	15,802,730	0.032660	85,917	2,806	54.00
60.00	06000	LABORATORY	52,095	10,897,490	0.004780	309,384	1,479	60.00
65.00	06500	RESPIRATORY THERAPY	310	201,717	0.001537	68,169	105	65.00
66.00	06600	PHYSICAL THERAPY	78,307	1,165,867	0.067166	43,444	2,918	66.00
67.00	06700	OCCUPATIONAL THERAPY	250	38,162	0.006551	8,353	55	67.00
68.00	06800	SPEECH PATHOLOGY	52	8,644	0.006016	444	3	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,603	710,785	0.016324	103,493	1,689	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,282	255,197	0.012861	9	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,768	3,422,562	0.013372	416,381	5,568	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
91.00	09100	EMERGENCY	118,815	15,094,472	0.007871	9,117	72	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	78,348	887,874	0.088242	13,244	1,169	92.00
200.00		Total (lines 50-199)	1,048,987	54,416,867		1,072,797	16,224	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,931,367	0.000000	0.000000	14,842	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	15,802,730	0.000000	0.000000	85,917	54.00
60.00	06000	LABORATORY	0	10,897,490	0.000000	0.000000	309,384	60.00
65.00	06500	RESPIRATORY THERAPY	0	201,717	0.000000	0.000000	68,169	65.00
66.00	06600	PHYSICAL THERAPY	0	1,165,867	0.000000	0.000000	43,444	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	38,162	0.000000	0.000000	8,353	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,644	0.000000	0.000000	444	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	710,785	0.000000	0.000000	103,493	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	255,197	0.000000	0.000000	9	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,422,562	0.000000	0.000000	416,381	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	15,094,472	0.000000	0.000000	9,117	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	887,874	0.000000	0.000000	13,244	92.00
200.00		Total (lines 50-199)	0	54,416,867			1,072,797	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.270124	0	1,847,920	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.181267	0	3,560,353	0	0	54.00
60.00	06000	LABORATORY	0.164238	0	3,745,579	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.044210	0	47,547	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.530850	0	241,970	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.335884	0	3,460	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.304951	0	1,892	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.336605	0	154,346	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.392230	0	82,751	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.259332	0	870,306	10,496	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.207936	0	3,188,589	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.023818	0	384,283	0	0	92.00
200.00		Subtotal (see instructions)		0	14,128,996	10,496	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	14,128,996	10,496	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	499,168	0		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	645,375	0		54.00
60.00	06000	LABORATORY	615,166	0		60.00
65.00	06500	RESPIRATORY THERAPY	2,102	0		65.00
66.00	06600	PHYSICAL THERAPY	128,450	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,162	0		67.00
68.00	06800	SPEECH PATHOLOGY	577	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,954	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	32,457	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	225,698	2,722		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	663,022	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	393,436	0		92.00
200.00		Subtotal (see instructions)	3,258,567	2,722		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,258,567	2,722		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151303 | Component CCN: 15Z303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.270124	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.181267	0	0	0	0	54.00
60.00	06000	LABORATORY	0.164238	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.044210	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.530850	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.335884	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.304951	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	0.336605	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.392230	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.259332	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	0.207936	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.023818	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 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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 07/01/2014 To 06/30/2015 | Worksheet D Part I Date/Time Prepared: 11/23/2015 8:22 am

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	199,926	28,512	171,414	1,503	114.05	30.00
200.00	Total (lines 30-199)	199,926		171,414	1,503		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	70	7,984	30.00
200.00	Total (lines 30-199)	70	7,984	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/23/2015 8:22 am

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	144,037	5,931,367	0.024284	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	516,120	15,802,730	0.032660	40,177	1,312	54.00
60.00	06000	LABORATORY	52,095	10,897,490	0.004780	54,004	258	60.00
65.00	06500	RESPIRATORY THERAPY	310	201,717	0.001537	0	0	65.00
66.00	06600	PHYSICAL THERAPY	78,307	1,165,867	0.067166	1,804	121	66.00
67.00	06700	OCCUPATIONAL THERAPY	250	38,162	0.006551	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	52	8,644	0.006016	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,603	710,785	0.016324	16,798	274	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,282	255,197	0.012861	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,768	3,422,562	0.013372	71,459	956	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
91.00	09100	EMERGENCY	118,815	15,094,472	0.007871	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	78,347	887,874	0.088241	0	0	92.00
200.00		Total (lines 50-199)	1,048,986	54,416,867		184,242	2,921	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part III Date/Time Prepared: 11/23/2015 8:22 am

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	1,503	0.00	70	0		30.00
200.00		Total (lines 30-199)	1,503		70	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/23/2015 8:22 am

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 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/23/2015 8:22 am

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	5,931,367	0.000000	0.000000	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	15,802,730	0.000000	0.000000	40,177	54.00
60.00	06000	LABORATORY	0	10,897,490	0.000000	0.000000	54,004	60.00
65.00	06500	RESPIRATORY THERAPY	0	201,717	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,165,867	0.000000	0.000000	1,804	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	38,162	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,644	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	710,785	0.000000	0.000000	16,798	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	255,197	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,422,562	0.000000	0.000000	71,459	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	15,094,472	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	887,874	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	54,416,867			184,242	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/23/2015 8:22 am

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 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,763	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,503	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)	914	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	125	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)	125	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	5	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)	5	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	528	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)	125	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)	125	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	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,706,759	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)	646	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)	646	25.00
26.00	Total swing-bed cost (see instructions)	387,127	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,319,632	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)	2,319,632	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)	1,543.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	814,884	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)	814,884	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	257,689	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,072,573	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)	192,918	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	192,918	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	385,836	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/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID 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)	589	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,543.33	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	909,021	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	199,926	2,319,632	0.086189	909,021	78,348	90.00
91.00	Nursing School cost	0	2,319,632	0.000000	909,021	0	91.00
92.00	Allied health cost	0	2,319,632	0.000000	909,021	0	92.00
93.00	All other Medical Education	0	2,319,632	0.000000	909,021	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/23/2015 8:22 am

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)	1,763	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,503	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)	914	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)	250	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	5	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)	5	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	70	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)	2,706,759	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)	386,017	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,320,742	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)	2,320,742	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)	1,544.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	108,085	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)	108,085	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/23/2015 8:22 am

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)	41,297	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	149,382	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)	7,984	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,921	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	10,905	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	138,477	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/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID 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)	589	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,544.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	909,457	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151303	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/23/2015 8:22 am
	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	199,926	2,320,742	0.086147	909,457	78,347	90.00
91.00	Nursing School cost	0	2,320,742	0.000000	909,457	0	91.00
92.00	Allied health cost	0	2,320,742	0.000000	909,457	0	92.00
93.00	All other Medical Education	0	2,320,742	0.000000	909,457	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		613,257		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.270124	14,842	4,009	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.181267	85,917	15,574	54.00
60.00	06000	LABORATORY	0.164238	309,384	50,813	60.00
65.00	06500	RESPIRATORY THERAPY	0.044210	68,169	3,014	65.00
66.00	06600	PHYSICAL THERAPY	0.530850	43,444	23,062	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.335884	8,353	2,806	67.00
68.00	06800	SPEECH PATHOLOGY	0.304951	444	135	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.336605	103,493	34,836	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.392230	9	4	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.259332	416,381	107,981	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.207936	9,117	1,896	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.023818	13,244	13,559	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,072,797	257,689	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)		1,072,797		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151303 | Component CCN: 15Z303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.270124	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.181267	18,161	3,292	54.00
60.00	06000	LABORATORY	0.164238	29,660	4,871	60.00
65.00	06500	RESPIRATORY THERAPY	0.044210	2,697	119	65.00
66.00	06600	PHYSICAL THERAPY	0.530850	94,024	49,913	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.335884	14,377	4,829	67.00
68.00	06800	SPEECH PATHOLOGY	0.304951	1,968	600	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.336605	18,436	6,206	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.392230	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.259332	81,433	21,118	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.207936	348	72	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.023818	264	270	92.00
200.00		Total (sum of lines 50-94 and 96-98)		261,368	91,290	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)		261,368		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/23/2015 8:22 am

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		151,625		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.270124	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.181267	40,177	7,283	54.00
60.00	06000	LABORATORY	0.164238	54,004	8,870	60.00
65.00	06500	RESPIRATORY THERAPY	0.044210	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.530850	1,804	958	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.335884	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.304951	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.336605	16,798	5,654	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.392230	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.259332	71,459	18,532	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
91.00	09100	EMERGENCY	0.207936	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.023818	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		184,242	41,297	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)		184,242		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151303	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/23/2015 8:22 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,261,289	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 Wkst. D, Pt. IV, col. 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)	3,261,289	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 Wkst. D-4, Pt. III, col. 4, line 69)	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)	3,293,902	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)	30,107	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,154,523	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,109,272	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,109,272	30.00
31.00	Primary payer payments	469	31.00
32.00	Subtotal (line 30 minus line 31)	1,108,803	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	827,635	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	629,003	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	473,367	36.00
37.00	Subtotal (see instructions)	1,737,806	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
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)	1,737,806	40.00
40.01	Sequestration adjustment (see instructions)	34,756	40.01
41.00	Interim payments	1,492,492	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	210,558	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 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		734,472		1,492,492	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)		734,472		1,492,492	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		198,180		210,558	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		932,652		1,703,050	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 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/23/2015 8:22 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		396,882		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)		396,882		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		72,343		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		469,225		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 07/01/2014 To 06/30/2015	Worksheet E-2 Date/Time Prepared: 11/23/2015 8:22 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	389,694	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	92,203	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	250	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)	481,897	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	481,897	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)	481,897	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,060	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)	476,837	0	15.00
16.00		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	2,691	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	1,964	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,947	0	18.00
19.00	Total (see instructions)	478,801	0	19.00
19.01	Sequestration adjustment (see instructions)	9,576	0	19.01
20.00	Interim payments	396,882	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)	72,343	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151303	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part V Date/Time Prepared: 11/23/2015 8:22 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,072,573	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,072,573	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,083,299	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)	1,083,299	19.00
20.00	Deductibles (exclude professional component)	157,336	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	925,963	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	925,963	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	33,846	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	25,723	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,656	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	951,686	28.00
29.00		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	951,686	30.00
30.01	Sequestration adjustment (see instructions)	19,034	30.01
31.00	Interim payments	734,472	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)	198,180	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 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 11/23/2015 8:22 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	7,075,701	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	5,548,332	0	0	0	4.00
5.00	Other receivable	3,374	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,492,530	0	0	0	6.00
7.00	Inventory	158,906	0	0	0	7.00
8.00	Prepaid expenses	169,381	0	0	0	8.00
9.00	Other current assets	3,026	0	0	0	9.00
10.00	Due from other funds	-209,354	209,354	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,256,836	209,354	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	-392,933	0	0	0	14.00
15.00	Buildings	13,681,541	0	0	0	15.00
16.00	Accumulated depreciation	-5,799,504	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	1,066,417	0	0	0	19.00
20.00	Accumulated depreciation	-912,378	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	3,849,020	0	0	0	23.00
24.00	Accumulated depreciation	-3,060,051	0	0	0	24.00
25.00	Minor equipment depreciable	26,387	0	0	0	25.00
26.00	Accumulated depreciation	-61,328	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)	8,934,894	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	166,158	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	166,158	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	18,357,888	209,354	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,157,776	0	0	0	37.00
38.00	Salaries, wages, and fees payable	592,200	0	0	0	38.00
39.00	Payroll taxes payable	46,484	0	0	0	39.00
40.00	Notes and loans payable (short term)	129,087	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	303,729	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,229,276	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,511,337	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-18,287	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	10,493,050	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	12,722,326	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	5,635,562				52.00
53.00	Specific purpose fund		209,354			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)	5,635,562	209,354	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,357,888	209,354	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151303 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 11/23/2015 8:22 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		6,369,445		185,898		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,375,567				2.00
3.00	Total (sum of line 1 and line 2)		7,745,012		185,898		3.00
4.00	GRANT/DONATION	0		66,541		0	4.00
5.00	INTERCOMPANY TRANSFERS	-1,785,262		0		0	5.00
6.00	PENSION ADJ	-329,341		0		0	6.00
7.00	RELEASED FROM RESTRICTION	5,153		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)		-2,109,450		66,541		10.00
11.00	Subtotal (line 3 plus line 10)		5,635,562		252,439		11.00
12.00	RELEASED CAPITAL	0		5,153		0	12.00
13.00	GRANT/DONATION	0		24,229		0	13.00
14.00	OTHER RESTRICTED	0		13,702		0	14.00
15.00	ROUNDING	0		1		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		43,085		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,635,562		209,354		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	GRANT/DONATION		0			4.00
5.00	INTERCOMPANY TRANSFERS		0			5.00
6.00	PENSION ADJ		0			6.00
7.00	RELEASED FROM RESTRICTION		0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	RELEASED CAPITAL		0			12.00
13.00	GRANT/DONATION		0			13.00
14.00	OTHER RESTRICTED		0			14.00
15.00	ROUNDING		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 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/23/2015 8:22 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,750,493		1,750,493	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)	1,750,493		1,750,493	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)	1,750,493		1,750,493	17.00
18.00	Ancillary services	2,169,099	35,407,959	37,577,058	18.00
19.00	Outpatient services	414,635	16,508,863	16,923,498	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	194,150	194,150	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,334,227	52,110,972	56,445,199	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,755,334		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00		0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		14,755,334		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151303	Period: From 07/01/2014 To 06/30/2015	Worksheet G-3 Date/Time Prepared: 11/23/2015 8:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	56,445,199	1.00
2.00	Less contractual allowances and discounts on patients' accounts	40,696,073	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,749,126	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,755,334	4.00
5.00	Net income from service to patients (line 3 minus line 4)	993,792	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	209,602	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	85,666	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	10,769	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	311,855	22.00
23.00	Governmental appropriations	0	23.00
24.00	GAINS AND LOSSES	0	24.00
24.01	ASSETS RELEASED FROM RESTRICTION	0	24.01
24.02	BARBER AND BEAUTY	-5,020	24.02
24.03	GAIN AND LOSS ON SALE OF ASSETS	952	24.03
24.04		0	24.04
24.05	NET ASSETS RELEASED	37,932	24.05
24.06	PHARMACY	6,836	24.06
25.00	Total other income (sum of lines 6-24)	658,592	25.00
26.00	Total (line 5 plus line 25)	1,652,384	26.00
27.00		0	27.00
27.01	UNREALIZED GAINS AND LOSSES	276,817	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	276,817	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,375,567	29.00