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: 151301	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/24/2015 10:18 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/24/2015 Time: 10:18 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT RANDOLPH HOSPITAL (151301) 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	187,080	58,451	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	25,169	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	212,249	58,451	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: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2015 10:23 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 473 GREENVILLE AVE.	PO Box:			1.00
2.00	City: WINCHESTER	State: IN	Zip Code: 47934	County: RANDOLPH	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 RANDOLPH HOSPITAL	151301	34620	1	01/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT RANDOLPH SWING BEDS	15Z301	34620		09/01/1999	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2014	06/30/2015	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	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: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2015 10:23 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.	N			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: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2015 10:23 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: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2015 10:23 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)	N	N	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)	N	N	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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2015 10:23 am

		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.	N	N	N	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:	77,700	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: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2015 10:23 am

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 10330 N. MERIDIAN ST. SUITE 420	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		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: 151301	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/21/2015 10:23 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: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2015 10:23 am

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

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

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for 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.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	10/12/2015	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: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 11/21/2015 10:23 am

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3232	JILL.HILL@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2015 10:23 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)	10/12/2015			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: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/21/2015 10:23 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	35,832.00	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	35,832.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	35,832.00	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2015 10:23 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)	537	19	1,493			1.00
2.00	HMO and other (see instructions)	103	388				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	214	0	214			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	40			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	751	19	1,747			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		340	539			13.00
14.00	Total (see instructions)	751	359	2,286	0.00	126.95	14.00
15.00	CAH visits	12,190	2,741	42,529			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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	126.95	27.00
28.00	Observation Bed Days		0	571			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	86	121			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: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2015 10:23 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	185	46	657	1.00
2.00	HMO and other (see instructions)			39	160		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	185	46	657	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-10 | Date/Time Prepared: 11/21/2015 10:23 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)	0.254376	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,122,289	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	3,164,493	5.00
6.00	Medicaid charges	18,250,847	6.00
7.00	Medicaid cost (line 1 times line 6)	4,642,577	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)	355,795	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)	355,795	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	5,664,883	422,181	6,087,064	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,441,010	107,393	1,548,403	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,441,010	107,393	1,548,403	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?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,603,922	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	650,284	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,953,638	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	496,959	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,045,362	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,401,157	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/21/2015 10:23 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,087,592	1,087,592	0	1,087,592	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		291,390	291,390	0	291,390	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	389,869	2,291,935	2,681,804	0	2,681,804	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,571,999	2,098,941	3,670,940	0	3,670,940	5.00
7.00	00700	OPERATION OF PLANT	115,771	1,480,335	1,596,106	0	1,596,106	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,456	68,456	0	68,456	8.00
9.00	00900	HOUSEKEEPING	0	466,512	466,512	0	466,512	9.00
10.00	01000	DIETARY	0	558,118	558,118	-322,172	235,946	10.00
11.00	01100	CAFETERIA	0	0	0	322,172	322,172	11.00
13.00	01300	NURSING ADMINISTRATION	595,220	78,507	673,727	0	673,727	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	64,349	28,250	92,599	0	92,599	14.00
15.00	01500	PHARMACY	271,676	1,223,010	1,494,686	0	1,494,686	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	194,023	68,184	262,207	0	262,207	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,384,688	267,718	1,652,406	-691,838	960,568	30.00
43.00	04300	NURSERY	0	0	0	215,135	215,135	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	416,629	681,586	1,098,215	-93,685	1,004,530	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	450,489	450,489	52.00
53.00	05300	ANESTHESIOLOGY	0	364	364	0	364	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	609,833	88,467	698,300	0	698,300	54.00
57.00	05700	CT SCAN	16,207	23,497	39,704	0	39,704	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	55,423	229,159	284,582	0	284,582	58.00
60.00	06000	LABORATORY	0	1,565,793	1,565,793	0	1,565,793	60.00
65.00	06500	RESPIRATORY THERAPY	394,642	57,088	451,730	0	451,730	65.00
65.01	03950	SLEEP LAB	99,027	-18,775	80,252	0	80,252	65.01
66.00	06600	PHYSICAL THERAPY	296,722	29,861	326,583	-4,185	322,398	66.00
67.00	06700	OCCUPATIONAL THERAPY	75,114	0	75,114	0	75,114	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	33,673	33,673	153,996	187,669	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	231,458	231,458	0	231,458	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	243,480	43,608	287,088	0	287,088	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	789,631	742,797	1,532,428	-29,912	1,502,516	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,584,303	13,717,524	21,301,827	0	21,301,827	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	36,645	2,342	38,987	0	38,987	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	-432	7,411	6,979	0	6,979	194.01
194.02	07952	OTHER NRCC - GRANTS	9,359	11,664	21,023	0	21,023	194.02
200.00		TOTAL (SUM OF LINES 118-199)	7,629,875	13,738,941	21,368,816	0	21,368,816	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/21/2015 10:23 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	-550,393	537,199		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-12,899	278,491		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-32,073	2,649,731		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,328,455	4,999,395		5.00
7.00	00700	OPERATION OF PLANT	-34,964	1,561,142		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,456		8.00
9.00	00900	HOUSEKEEPING	0	466,512		9.00
10.00	01000	DIETARY	0	235,946		10.00
11.00	01100	CAFETERIA	-74,948	247,224		11.00
13.00	01300	NURSING ADMINISTRATION	-105	673,622		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	92,599		14.00
15.00	01500	PHARMACY	-837	1,493,849		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-10,055	252,152		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-52,179	908,389		30.00
43.00	04300	NURSERY	0	215,135		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-181,831	822,699		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	450,489		52.00
53.00	05300	ANESTHESIOLOGY	0	364		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,928	695,372		54.00
57.00	05700	CT SCAN	0	39,704		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	284,582		58.00
60.00	06000	LABORATORY	0	1,565,793		60.00
65.00	06500	RESPIRATORY THERAPY	0	451,730		65.00
65.01	03950	SLEEP LAB	0	80,252		65.01
66.00	06600	PHYSICAL THERAPY	-5,332	317,066		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	75,114		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	187,669		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	231,458		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	287,088		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-254,069	1,248,447		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	115,842	21,417,669		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	38,987		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	120,729	120,729		194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	6,979		194.01
194.02	07952	OTHER NRCC - GRANTS	0	21,023		194.02
200.00		TOTAL (SUM OF LINES 118-199)	236,571	21,605,387		200.00

RECLASSIFICATIONS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/21/2015 10:23 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	0	322,172	1.00
	TOTALS		0	322,172	
	C - NURSERY RECLASS				
1.00	NURSERY	43.00	184,770	34,744	1.00
	TOTALS		184,770	34,744	
	D - LDR RECLASS				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	386,906	72,753	1.00
	TOTALS		386,906	72,753	
	E - MEDICAL SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	153,996	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	153,996	
500.00	Grand Total: Increases		571,676	583,665	500.00

RECLASSIFICATIONS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/21/2015 10:23 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	322,172	0		1.00
	TOTALS		0	322,172			
	C - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	184,770	34,744	0		1.00
	TOTALS		184,770	34,744			
	D - LDR RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	386,906	72,753	0		1.00
	TOTALS		386,906	72,753			
	E - MEDICAL SUPPLIES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	12,665	0		1.00
2.00	NURSERY	43.00	0	4,379	0		2.00
3.00	OPERATING ROOM	50.00	0	93,685	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	9,170	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	4,185	0		5.00
6.00	EMERGENCY	91.00	0	29,912	0		6.00
	TOTALS		0	153,996			
500.00	Grand Total: Decreases		571,676	583,665			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I Date/Time Prepared: 11/21/2015 10:23 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	696,652	0	0	0	0	1.00
2.00	Land Improvements	25,100	0	0	0	25,100	2.00
3.00	Buildings and Fixtures	18,042,103	0	0	0	14,520	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	592,548	0	0	0	161,076	5.00
6.00	Movable Equipment	5,463,275	0	0	0	213,342	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,819,678	0	0	0	414,038	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,819,678	0	0	0	414,038	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	696,652	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	18,027,583	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	431,472	0	5.00
6.00	Movable Equipment	5,249,933	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,405,640	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	24,405,640	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 11/21/2015 10:23 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	1,087,592	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	289,035	0	0	2,355	0	2.00
3.00	Total (sum of lines 1-2)	1,376,627	0	0	2,355	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	1,087,592	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	291,390	2.00
3.00	Total (sum of lines 1-2)	0	1,378,982	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 11/21/2015 10:23 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	19,155,707	0	19,155,707	0.784889	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,249,933	0	5,249,933	0.215111	0	2.00
3.00	Total (sum of lines 1-2)	24,405,640	0	24,405,640	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	537,199	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	276,136	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	813,335	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	0	0	0	0	537,199	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,355	0	0	278,491	2.00
3.00	Total (sum of lines 1-2)	0	2,355	0	0	815,690	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/21/2015 10:23 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)	A	-330,054	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	A	-16,529	CAP REL COSTS-BLDG & FIXT	1.00	9	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-490,618			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	1,830,496			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-74,948	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		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PROVIDER ASSESSMENT TAX ADJUSTMENT	A	-427,634	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/21/2015 10:23 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	OTHER OPERATING INCOME	B	-1,505	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ACCRUED INCENTIVES	A	-115,060	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	OTHER PHARMACY REVENUE	B	-837	PHARMACY	15.00	0	33.04
33.05	OTHER HIM REVENUE	B	-10,055	MEDICAL RECORDS & LIBRARY	16.00	0	33.05
33.06	OTHER OPERATING REVENUE	B	-831	ADULTS & PEDIATRICS	30.00	0	33.06
33.08	OTHER RADIOLOGY REVENUE	B	-25	RADIOLOGY-DIAGNOSTIC	54.00	0	33.08
33.09	OTHER PHYSICAL THERAPY REVENUE	B	-4,177	PHYSICAL THERAPY	66.00	0	33.09
33.10	DONATIONS	A	-75	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	AHA & IHA DUES	A	-710	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.13	PAVILION DEPRECIATION	A	-2,507	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
33.14	CARRYFORWARD ON HOSPITAL DEPR.	A	-104,668	CAP REL COSTS-BLDG & FIXT	1.00	9	33.14
33.16	LOSS ON SALE OF PPE	A	-12,899	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.16
33.17	HOSPITALIST	A	-688	ADULTS & PEDIATRICS	30.00	0	33.17
33.18	NON REIMB EXPENSE	A	-105	NURSING ADMINISTRATION	13.00	0	33.18
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		236,571				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: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 11/21/2015 10:23 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	88,820	88,820	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,942,911	1,184,532	2.00
3.00	194.00	OTHER NRCC - PUBLIC RELATION	HOME OFFICE	120,729	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ST. VINCENT HLTH CHARGEBACK	202,754	202,754	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HLTH CHARGEBACK	838,229	838,229	4.01
4.02	9.00	HOUSEKEEPING	ST. VINCENT HLTH CHARGEBACK	-90,311	-90,311	4.02
4.03	14.00	CENTRAL SERVICES & SUPPLY	ST. VINCENT HLTH CHARGEBACK	75,980	75,980	4.03
4.04	15.00	PHARMACY	ST. VINCENT HLTH CHARGEBACK	-141,360	-141,360	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HLTH CHARGEBACK	174,549	174,549	4.05
4.06	13.00	NURSING ADMINISTRATION	ST. VINCENT HLTH CHARGEBACK	-16,500	-16,500	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	ST. VINCENT HLTH CHARGEBACK	61,486	61,486	4.07
4.08	194.00	OTHER NRCC - PUBLIC RELATION	ST. VINCENT HLTH CHARGEBACK	-33,350	-33,350	4.08
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	1,041,435	1,189,328	4.10
4.11	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	333,054	425,120	4.11
4.12	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	16,529	21,098	4.12
4.13	7.00	OPERATION OF PLANT	TRIMEDX	875,732	910,696	4.13
4.14	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	323,315	92,435	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	0.00			0	0	4.18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
5.00	0		0	6,814,002	4,983,506	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 HTH	100.00	ST. VINCENT HTH	100.00	6.00
7.00	G	ASCENSION	100.00	ASCENSION	100.00	7.00
8.00	B	ST. VINCENT HSP	100.00	ST. VINCENT HSP	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: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 11/21/2015 10:23 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	1,758,379	0		2.00
3.00	120,729	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
4.10	-147,893	0		4.10
4.11	-92,066	9		4.11
4.12	-4,569	9		4.12
4.13	-34,964	0		4.13
4.14	230,880	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
5.00	1,830,496			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	ADMINISTRATION		7.00
8.00	HOSPITAL		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: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 11/21/2015 10:23 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	50,660	50,660	0	0	0	1.00
2.00	50.00	OPERATING ROOM	181,831	181,831	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	2,903	2,903	0	0	0	3.00
4.00	66.00	PHYSICAL THERAPY	1,155	1,155	0	0	0	4.00
5.00	91.00	EMERGENCY	577,429	254,069	323,360	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			813,978	490,618	323,360		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	50,660		1.00
2.00	50.00	OPERATING ROOM	0	0	0	181,831		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	2,903		3.00
4.00	66.00	PHYSICAL THERAPY	0	0	0	1,155		4.00
5.00	91.00	EMERGENCY	0	0	0	254,069		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	490,618		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/21/2015 10:23 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	537,199	537,199				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	278,491		278,491			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,649,731	0	0	2,649,731		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,999,395	84,512	43,812	576,124	5,703,843	5.00
7.00	00700	OPERATION OF PLANT	1,561,142	32,099	16,640	42,429	1,652,310	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	68,456	4,382	2,272	0	75,110	8.00
9.00	00900	HOUSEKEEPING	466,512	4,108	2,130	0	472,750	9.00
10.00	01000	DIETARY	235,946	15,241	7,901	0	259,088	10.00
11.00	01100	CAFETERIA	247,224	3,588	1,860	0	252,672	11.00
13.00	01300	NURSING ADMINISTRATION	673,622	986	511	218,142	893,261	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	92,599	0	0	23,583	116,182	14.00
15.00	01500	PHARMACY	1,493,849	0	0	99,566	1,593,415	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	252,152	10,154	5,264	71,107	338,677	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	908,389	62,554	32,429	294,570	1,297,942	30.00
43.00	04300	NURSERY	215,135	856	444	67,716	284,151	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	822,699	52,893	27,420	152,690	1,055,702	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	450,489	16,084	8,338	141,797	616,708	52.00
53.00	05300	ANESTHESIOLOGY	364	0	0	0	364	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	695,372	42,609	22,089	223,497	983,567	54.00
57.00	05700	CT SCAN	39,704	0	0	5,940	45,644	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	284,582	0	0	20,312	304,894	58.00
60.00	06000	LABORATORY	1,565,793	11,934	6,187	0	1,583,914	60.00
65.00	06500	RESPIRATORY THERAPY	451,730	12,455	6,457	144,632	615,274	65.00
65.01	03950	SLEEP LAB	80,252	2,903	1,505	36,292	120,952	65.01
66.00	06600	PHYSICAL THERAPY	317,066	20,575	10,666	108,322	456,629	66.00
67.00	06700	OCCUPATIONAL THERAPY	75,114	2,170	1,125	27,528	105,937	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	187,669	11,523	5,974	0	205,166	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	231,458	0	0	0	231,458	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	287,088	7,922	4,107	89,233	388,350	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,248,447	29,093	15,082	289,391	1,582,013	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,417,669	428,641	222,213	2,632,871	21,235,973	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	876	454	0	1,330	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,987	106,778	55,356	13,430	214,551	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	120,729	452	234	0	121,415	194.00
194.01	07951	OTHER NRCC - FOUNDATION	6,979	452	234	0	7,665	194.01
194.02	07952	OTHER NRCC - GRANTS	21,023	0	0	3,430	24,453	194.02
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)	21,605,387	537,199	278,491	2,649,731	21,605,387	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/21/2015 10:23 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,703,843					5.00
7.00	00700	OPERATION OF PLANT	592,688	2,244,998				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,942	23,390	125,442			8.00
9.00	00900	HOUSEKEEPING	169,574	21,928	0	664,252		9.00
10.00	01000	DIETARY	92,934	81,355	0	24,567	457,944	10.00
11.00	01100	CAFETERIA	90,633	19,151	0	5,783	0	11.00
13.00	01300	NURSING ADMINISTRATION	320,410	5,263	0	1,589	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	41,674	0	0	0	0	14.00
15.00	01500	PHARMACY	571,553	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	121,482	54,200	0	16,367	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	465,568	333,897	48,443	100,829	457,944	30.00
43.00	04300	NURSERY	101,924	4,568	0	1,380	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	378,677	282,329	13,999	85,257	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	221,211	85,850	0	25,925	0	52.00
53.00	05300	ANESTHESIOLOGY	131	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	352,803	227,435	14,003	68,680	0	54.00
57.00	05700	CT SCAN	16,372	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	109,365	0	0	0	0	58.00
60.00	06000	LABORATORY	568,145	63,702	0	19,237	0	60.00
65.00	06500	RESPIRATORY THERAPY	220,697	66,480	0	20,075	0	65.00
65.01	03950	SLEEP LAB	43,385	15,496	0	4,679	0	65.01
66.00	06600	PHYSICAL THERAPY	163,791	109,825	0	33,165	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	37,999	11,586	0	3,499	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	73,592	61,509	0	18,574	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	83,023	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	139,300	42,285	0	12,769	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	567,463	155,290	48,997	46,894	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,571,336	1,665,539	125,442	489,269	457,944	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	477	4,678	0	1,413	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	76,959	569,957	0	172,114	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	43,551	2,412	0	728	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	2,749	2,412	0	728	0	194.01
194.02	07952	OTHER NRCC - GRANTS	8,771	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,703,843	2,244,998	125,442	664,252	457,944	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/21/2015 10:23 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	368,239					11.00
13.00	01300	NURSING ADMINISTRATION	32,894	1,253,417				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,583	0	165,439			14.00
15.00	01500	PHARMACY	10,728	0	0	2,175,696		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,150	0	0	0	550,876	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	56,483	389,455	0	0	23,395	30.00
43.00	04300	NURSERY	12,834	88,493	0	0	6,915	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,226	167,041	0	0	69,568	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,876	185,310	0	0	14,469	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	5,201	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,090	0	0	0	55,214	54.00
57.00	05700	CT SCAN	685	0	0	0	79,304	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,078	0	0	0	16,722	58.00
60.00	06000	LABORATORY	0	0	0	0	125,549	60.00
65.00	06500	RESPIRATORY THERAPY	26,832	0	0	0	20,630	65.00
65.01	03950	SLEEP LAB	6,076	0	0	0	4,898	65.01
66.00	06600	PHYSICAL THERAPY	20,400	0	0	0	12,899	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,646	0	0	0	2,482	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	74,533	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	90,906	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,699	0	0	2,175,696	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	57,249	394,733	0	0	113,630	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	362,529	1,225,032	165,439	2,175,696	550,876	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	4,117	28,385	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	1,582	0	0	0	0	194.01
194.02	07952	OTHER NRCC - GRANTS	11	0	0	0	0	194.02
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)	368,239	1,253,417	165,439	2,175,696	550,876	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/21/2015 10:23 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
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	3,173,956	0	3,173,956		30.00
43.00	04300	NURSERY	500,265	0	500,265		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,076,799	0	2,076,799		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,176,349	0	1,176,349		52.00
53.00	05300	ANESTHESIOLOGY	5,696	0	5,696		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,740,792	0	1,740,792		54.00
57.00	05700	CT SCAN	142,005	0	142,005		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	434,059	0	434,059		58.00
60.00	06000	LABORATORY	2,360,547	0	2,360,547		60.00
65.00	06500	RESPIRATORY THERAPY	969,988	0	969,988		65.00
65.01	03950	SLEEP LAB	195,486	0	195,486		65.01
66.00	06600	PHYSICAL THERAPY	796,709	0	796,709		66.00
67.00	06700	OCCUPATIONAL THERAPY	165,149	0	165,149		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	433,374	0	433,374		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	405,387	0	405,387		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,772,099	0	2,772,099		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	2,966,269	0	2,966,269		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,314,929	0	20,314,929		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,898	0	7,898		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,066,083	0	1,066,083		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	168,106	0	168,106		194.00
194.01	07951	OTHER NRCC - FOUNDATION	15,136	0	15,136		194.01
194.02	07952	OTHER NRCC - GRANTS	33,235	0	33,235		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	21,605,387	0	21,605,387		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/21/2015 10:23 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	308,421	84,512	43,812	436,745	0	5.00
7.00	00700	OPERATION OF PLANT	0	32,099	16,640	48,739	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,382	2,272	6,654	0	8.00
9.00	00900	HOUSEKEEPING	0	4,108	2,130	6,238	0	9.00
10.00	01000	DIETARY	0	15,241	7,901	23,142	0	10.00
11.00	01100	CAFETERIA	0	3,588	1,860	5,448	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	986	511	1,497	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	-13,527	0	0	-13,527	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,563	10,154	5,264	17,981	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	55,272	62,554	32,429	150,255	0	30.00
43.00	04300	NURSERY	0	856	444	1,300	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	46,081	52,893	27,420	126,394	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	16,084	8,338	24,422	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	42,609	22,089	64,698	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	228,885	0	0	228,885	0	58.00
60.00	06000	LABORATORY	0	11,934	6,187	18,121	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,226	12,455	6,457	22,138	0	65.00
65.01	03950	SLEEP LAB	0	2,903	1,505	4,408	0	65.01
66.00	06600	PHYSICAL THERAPY	1,722	20,575	10,666	32,963	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,170	1,125	3,295	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,523	5,974	17,497	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	406	7,922	4,107	12,435	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,483	29,093	15,082	47,658	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	636,532	428,641	222,213	1,287,386	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	876	454	1,330	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	300	106,778	55,356	162,434	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	452	234	686	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	452	234	686	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
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)	636,832	537,199	278,491	1,452,522	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/21/2015 10:23 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	436,745					5.00
7.00	00700	OPERATION OF PLANT	45,373	94,112				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,063	981	9,698			8.00
9.00	00900	HOUSEKEEPING	12,985	919	0	20,142		9.00
10.00	01000	DIETARY	7,116	3,410	0	745	34,413	10.00
11.00	01100	CAFETERIA	6,940	803	0	175	0	11.00
13.00	01300	NURSING ADMINISTRATION	24,534	221	0	48	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,191	0	0	0	0	14.00
15.00	01500	PHARMACY	43,765	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,302	2,272	0	496	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,649	13,997	3,745	3,057	34,413	30.00
43.00	04300	NURSERY	7,804	192	0	42	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,996	11,835	1,082	2,585	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,939	3,599	0	786	0	52.00
53.00	05300	ANESTHESIOLOGY	10	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,015	9,534	1,083	2,083	0	54.00
57.00	05700	CT SCAN	1,254	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,374	0	0	0	0	58.00
60.00	06000	LABORATORY	43,504	2,670	0	583	0	60.00
65.00	06500	RESPIRATORY THERAPY	16,899	2,787	0	609	0	65.00
65.01	03950	SLEEP LAB	3,322	650	0	142	0	65.01
66.00	06600	PHYSICAL THERAPY	12,542	4,604	0	1,006	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,910	486	0	106	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,635	2,579	0	563	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,357	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,666	1,773	0	387	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	43,452	6,510	3,788	1,422	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	426,597	69,822	9,698	14,835	34,413	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37	196	0	43	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,893	23,892	0	5,220	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	3,335	101	0	22	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	211	101	0	22	0	194.01
194.02	07952	OTHER NRCC - GRANTS	672	0	0	0	0	194.02
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)	436,745	94,112	9,698	20,142	34,413	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/21/2015 10:23 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	13,366					11.00
13.00	01300	NURSING ADMINISTRATION	1,194	27,494				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	275	0	3,466			14.00
15.00	01500	PHARMACY	389	0	0	30,627		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	731	0	0	0	30,782	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,050	8,543	0	0	1,307	30.00
43.00	04300	NURSERY	466	1,941	0	0	386	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	879	3,664	0	0	3,886	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	976	4,065	0	0	808	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	291	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,419	0	0	0	3,084	54.00
57.00	05700	CT SCAN	25	0	0	0	4,430	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	112	0	0	0	934	58.00
60.00	06000	LABORATORY	0	0	0	0	7,023	60.00
65.00	06500	RESPIRATORY THERAPY	974	0	0	0	1,152	65.00
65.01	03950	SLEEP LAB	221	0	0	0	274	65.01
66.00	06600	PHYSICAL THERAPY	740	0	0	0	721	66.00
67.00	06700	OCCUPATIONAL THERAPY	132	0	0	0	139	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,561	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,905	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	497	0	0	30,627	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,080	8,658	0	0	6,347	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,160	26,871	3,466	30,627	30,782	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	149	623	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	57	0	0	0	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
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)	13,366	27,494	3,466	30,627	30,782	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/21/2015 10:23 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
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	253,016	0	253,016		30.00
43.00	04300	NURSERY	12,131	0	12,131		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	179,321	0	179,321		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,595	0	51,595		52.00
53.00	05300	ANESTHESIOLOGY	301	0	301		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	108,916	0	108,916		54.00
57.00	05700	CT SCAN	5,709	0	5,709		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	238,305	0	238,305		58.00
60.00	06000	LABORATORY	71,901	0	71,901		60.00
65.00	06500	RESPIRATORY THERAPY	44,559	0	44,559		65.00
65.01	03950	SLEEP LAB	9,017	0	9,017		65.01
66.00	06600	PHYSICAL THERAPY	52,576	0	52,576		66.00
67.00	06700	OCCUPATIONAL THERAPY	7,068	0	7,068		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,835	0	27,835		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,262	0	8,262		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,385	0	56,385		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	119,915	0	119,915		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,246,812	0	1,246,812		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,606	0	1,606		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	198,211	0	198,211		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	4,144	0	4,144		194.00
194.01	07951	OTHER NRCC - FOUNDATION	1,077	0	1,077		194.01
194.02	07952	OTHER NRCC - GRANTS	672	0	672		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,452,522	0	1,452,522		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/21/2015 10:23 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	78,458					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		78,458				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,230,033			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,343	12,343	1,571,999	-5,703,843	15,901,544	5.00
7.00	00700	OPERATION OF PLANT	4,688	4,688	115,771	0	1,652,310	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	640	640	0	0	75,110	8.00
9.00	00900	HOUSEKEEPING	600	600	0	0	472,750	9.00
10.00	01000	DIETARY	2,226	2,226	0	0	259,088	10.00
11.00	01100	CAFETERIA	524	524	0	0	252,672	11.00
13.00	01300	NURSING ADMINISTRATION	144	144	595,220	0	893,261	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	64,349	0	116,182	14.00
15.00	01500	PHARMACY	0	0	271,676	0	1,593,415	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,483	1,483	194,023	0	338,677	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,136	9,136	803,762	0	1,297,942	30.00
43.00	04300	NURSERY	125	125	184,770	0	284,151	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,725	7,725	416,629	0	1,055,702	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,349	2,349	386,906	0	616,708	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	364	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,223	6,223	609,833	0	983,567	54.00
57.00	05700	CT SCAN	0	0	16,207	0	45,644	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	55,423	0	304,894	58.00
60.00	06000	LABORATORY	1,743	1,743	0	0	1,583,914	60.00
65.00	06500	RESPIRATORY THERAPY	1,819	1,819	394,642	0	615,274	65.00
65.01	03950	SLEEP LAB	424	424	99,027	0	120,952	65.01
66.00	06600	PHYSICAL THERAPY	3,005	3,005	295,567	0	456,629	66.00
67.00	06700	OCCUPATIONAL THERAPY	317	317	75,114	0	105,937	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,683	1,683	0	0	205,166	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	231,458	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,157	1,157	243,480	0	388,350	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,249	4,249	789,631	0	1,582,013	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,603	62,603	7,184,029	-5,703,843	15,532,130	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	128	128	0	0	1,330	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,595	15,595	36,645	0	214,551	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	66	66	0	0	121,415	194.00
194.01	07951	OTHER NRCC - FOUNDATION	66	66	0	0	7,665	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	9,359	0	24,453	194.02
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)	537,199	278,491	2,649,731		5,703,843	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.846963	3.549555	0.366489		0.358697	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		436,745	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.027466	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/21/2015 10:23 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	61,427					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	640	90,166				8.00
9.00	00900	HOUSEKEEPING	600	0	60,187			9.00
10.00	01000	DIETARY	2,226	0	2,226	100		10.00
11.00	01100	CAFETERIA	524	0	524	0	192,493	11.00
13.00	01300	NURSING ADMINISTRATION	144	0	144	0	17,195	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	3,964	14.00
15.00	01500	PHARMACY	0	0	0	0	5,608	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,483	0	1,483	0	10,533	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,136	34,820	9,136	100	29,526	30.00
43.00	04300	NURSERY	125	0	125	0	6,709	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,725	10,062	7,725	0	12,664	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,349	0	2,349	0	14,049	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,223	10,065	6,223	0	20,434	54.00
57.00	05700	CT SCAN	0	0	0	0	358	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	1,609	58.00
60.00	06000	LABORATORY	1,743	0	1,743	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,819	0	1,819	0	14,026	65.00
65.01	03950	SLEEP LAB	424	0	424	0	3,176	65.01
66.00	06600	PHYSICAL THERAPY	3,005	0	3,005	0	10,664	66.00
67.00	06700	OCCUPATIONAL THERAPY	317	0	317	0	1,906	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,683	0	1,683	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,157	0	1,157	0	7,161	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,249	35,219	4,249	0	29,926	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,572	90,166	44,332	100	189,508	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	128	0	128	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,595	0	15,595	0	2,152	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	66	0	66	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	66	0	66	0	827	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	6	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,244,998	125,442	664,252	457,944	368,239	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.547414	1.391234	11.036470	4,579.440000	1.912999	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	94,112	9,698	20,142	34,413	13,366	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.532095	0.107557	0.334657	344.130000	0.069436	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/21/2015 10:23 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	95,026					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	421,230				14.00
15.00	01500	PHARMACY	0	0	10,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	68,690,054		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,526	0	0	2,917,126		30.00
43.00	04300	NURSERY	6,709	0	0	862,201		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,664	0	0	8,674,283		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,049	0	0	1,804,084		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	648,507		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,884,535		54.00
57.00	05700	CT SCAN	0	0	0	9,888,328		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,084,992		58.00
60.00	06000	LABORATORY	0	0	0	15,656,693		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,572,371		65.00
65.01	03950	SLEEP LAB	0	0	0	610,712		65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	1,608,344		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	309,518		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	189,772	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	231,458	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	10,000	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	29,926	0	0	14,168,360		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	92,874	421,230	10,000	68,690,054		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,152	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0		194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	0	0	0		194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,253,417	165,439	2,175,696	550,876		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.190253	0.392752	217.569600	0.008020		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	27,494	3,466	30,627	30,782		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.289331	0.008228	3.062700	0.000448		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/21/2015 10:23 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	3,173,956		3,173,956	0	0	30.00
43.00	04300	NURSERY	500,265		500,265	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,076,799		2,076,799	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,176,349		1,176,349	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,696		5,696	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,740,792		1,740,792	0	0	54.00
57.00	05700	CT SCAN	142,005		142,005	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	434,059		434,059	0	0	58.00
60.00	06000	LABORATORY	2,360,547		2,360,547	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	969,988	0	969,988	0	0	65.00
65.01	03950	SLEEP LAB	195,486	0	195,486	0	0	65.01
66.00	06600	PHYSICAL THERAPY	796,709	0	796,709	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	165,149	0	165,149	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	433,374		433,374	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	405,387		405,387	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,772,099		2,772,099	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,966,269		2,966,269	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	794,284		794,284		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	21,109,213	0	21,109,213	0	0	200.00
201.00		Less Observation Beds	794,284		794,284		0	201.00
202.00		Total (see instructions)	20,314,929	0	20,314,929	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/21/2015 10:23 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,152,450		2,152,450			30.00
43.00	04300	NURSERY	862,201		862,201			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,183,752	6,490,531	8,674,283	0.239420	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,360,279	443,805	1,804,084	0.652048	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	117,479	531,028	648,507	0.008783	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	171,362	6,713,173	6,884,535	0.252855	0.000000	54.00
57.00	05700	CT SCAN	256,348	9,631,980	9,888,328	0.014361	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20,400	2,064,592	2,084,992	0.208183	0.000000	58.00
60.00	06000	LABORATORY	968,579	14,688,114	15,656,693	0.150769	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	687,009	1,885,362	2,572,371	0.377079	0.000000	65.00
65.01	03950	SLEEP LAB	0	610,712	610,712	0.320095	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	128,256	1,480,088	1,608,344	0.495360	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	37,304	272,214	309,518	0.533568	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	596,197	1,534,560	2,130,757	0.203390	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	457,754	303,095	760,849	0.532809	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,313,269	6,967,030	8,280,299	0.334782	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	209,077	13,959,283	14,168,360	0.209359	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	564	764,112	764,676	1.038720	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	11,522,280	68,339,679	79,861,959			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,522,280	68,339,679	79,861,959			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/21/2015 10:23 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	03950	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
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: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/21/2015 10:23 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,173,956		3,173,956	0	3,173,956	30.00
43.00	04300	NURSERY	500,265		500,265	0	500,265	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,076,799		2,076,799	0	2,076,799	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,176,349		1,176,349	0	1,176,349	52.00
53.00	05300	ANESTHESIOLOGY	5,696		5,696	0	5,696	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,740,792		1,740,792	0	1,740,792	54.00
57.00	05700	CT SCAN	142,005		142,005	0	142,005	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	434,059		434,059	0	434,059	58.00
60.00	06000	LABORATORY	2,360,547		2,360,547	0	2,360,547	60.00
65.00	06500	RESPIRATORY THERAPY	969,988	0	969,988	0	969,988	65.00
65.01	03950	SLEEP LAB	195,486	0	195,486	0	195,486	65.01
66.00	06600	PHYSICAL THERAPY	796,709	0	796,709	0	796,709	66.00
67.00	06700	OCCUPATIONAL THERAPY	165,149	0	165,149	0	165,149	67.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	433,374		433,374	0	433,374	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	405,387		405,387	0	405,387	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,772,099		2,772,099	0	2,772,099	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,966,269		2,966,269	0	2,966,269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	794,284		794,284		794,284	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	21,109,213	0	21,109,213	0	21,109,213	200.00
201.00		Less Observation Beds	794,284		794,284		794,284	201.00
202.00		Total (see instructions)	20,314,929	0	20,314,929	0	20,314,929	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/21/2015 10:23 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,152,450		2,152,450			30.00
43.00	04300	NURSERY	862,201		862,201			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,183,752	6,490,531	8,674,283	0.239420	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,360,279	443,805	1,804,084	0.652048	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	117,479	531,028	648,507	0.008783	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	171,362	6,713,173	6,884,535	0.252855	0.000000	54.00
57.00	05700	CT SCAN	256,348	9,631,980	9,888,328	0.014361	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20,400	2,064,592	2,084,992	0.208183	0.000000	58.00
60.00	06000	LABORATORY	968,579	14,688,114	15,656,693	0.150769	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	687,009	1,885,362	2,572,371	0.377079	0.000000	65.00
65.01	03950	SLEEP LAB	0	610,712	610,712	0.320095	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	128,256	1,480,088	1,608,344	0.495360	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	37,304	272,214	309,518	0.533568	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	596,197	1,534,560	2,130,757	0.203390	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	457,754	303,095	760,849	0.532809	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,313,269	6,967,030	8,280,299	0.334782	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	209,077	13,959,283	14,168,360	0.209359	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	564	764,112	764,676	1.038720	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	11,522,280	68,339,679	79,861,959			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,522,280	68,339,679	79,861,959			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/21/2015 10:23 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	03950	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
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: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part II Date/Time Prepared: 11/21/2015 10:23 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,076,799	179,321	1,897,478	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,176,349	51,595	1,124,754	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,696	301	5,395	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,740,792	108,916	1,631,876	0	0	54.00
57.00	05700	CT SCAN	142,005	5,709	136,296	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	434,059	238,305	195,754	0	0	58.00
60.00	06000	LABORATORY	2,360,547	71,901	2,288,646	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	969,988	44,559	925,429	0	0	65.00
65.01	03950	SLEEP LAB	195,486	9,017	186,469	0	0	65.01
66.00	06600	PHYSICAL THERAPY	796,709	52,576	744,133	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	165,149	7,068	158,081	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	433,374	27,835	405,539	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	405,387	8,262	397,125	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,772,099	56,385	2,715,714	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,966,269	119,915	2,846,354	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	794,284	69,996	724,288	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	17,434,992	1,051,661	16,383,331	0	0	200.00
201.00		Less Observation Beds	794,284	69,996	724,288	0	0	201.00
202.00		Total (line 200 minus line 201)	16,640,708	981,665	15,659,043	0	0	202.00

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

Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part II Date/Time Prepared: 11/21/2015 10:23 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,076,799	8,674,283	0.239420		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,176,349	1,804,084	0.652048		52.00
53.00	05300	ANESTHESIOLOGY	5,696	648,507	0.008783		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,740,792	6,884,535	0.252855		54.00
57.00	05700	CT SCAN	142,005	9,888,328	0.014361		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	434,059	2,084,992	0.208183		58.00
60.00	06000	LABORATORY	2,360,547	15,656,693	0.150769		60.00
65.00	06500	RESPIRATORY THERAPY	969,988	2,572,371	0.377079		65.00
65.01	03950	SLEEP LAB	195,486	610,712	0.320095		65.01
66.00	06600	PHYSICAL THERAPY	796,709	1,608,344	0.495360		66.00
67.00	06700	OCCUPATIONAL THERAPY	165,149	309,518	0.533568		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	433,374	2,130,757	0.203390		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	405,387	760,849	0.532809		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,772,099	8,280,299	0.334782		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	2,966,269	14,168,360	0.209359		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	794,284	764,676	1.038720		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	17,434,992	76,847,308			200.00
201.00		Less Observation Beds	794,284	0			201.00
202.00		Total (line 200 minus line 201)	16,640,708	76,847,308			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/21/2015 10:23 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	179,321	8,674,283	0.020673	412,722	8,532	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,595	1,804,084	0.028599	4,293	123	52.00
53.00	05300	ANESTHESIOLOGY	301	648,507	0.000464	24,487	11	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	108,916	6,884,535	0.015820	27,600	437	54.00
57.00	05700	CT SCAN	5,709	9,888,328	0.000577	66,516	38	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	238,305	2,084,992	0.114295	6,823	780	58.00
60.00	06000	LABORATORY	71,901	15,656,693	0.004592	213,727	981	60.00
65.00	06500	RESPIRATORY THERAPY	44,559	2,572,371	0.017322	376,484	6,521	65.00
65.01	03950	SLEEP LAB	9,017	610,712	0.014765	0	0	65.01
66.00	06600	PHYSICAL THERAPY	52,576	1,608,344	0.032690	35,491	1,160	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,068	309,518	0.022836	14,966	342	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,835	2,130,757	0.013063	208,809	2,728	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,262	760,849	0.010859	177,186	1,924	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,385	8,280,299	0.006810	417,337	2,842	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	119,915	14,168,360	0.008464	12,197	103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	69,996	764,676	0.091537	564	52	92.00
200.00		Total (lines 50-199)	1,051,661	76,847,308		1,999,202	26,574	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/21/2015 10:23 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/21/2015 10:23 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	8,674,283	0.000000	0.000000	412,722	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,804,084	0.000000	0.000000	4,293	52.00
53.00	05300	ANESTHESIOLOGY	0	648,507	0.000000	0.000000	24,487	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,884,535	0.000000	0.000000	27,600	54.00
57.00	05700	CT SCAN	0	9,888,328	0.000000	0.000000	66,516	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,084,992	0.000000	0.000000	6,823	58.00
60.00	06000	LABORATORY	0	15,656,693	0.000000	0.000000	213,727	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,572,371	0.000000	0.000000	376,484	65.00
65.01	03950	SLEEP LAB	0	610,712	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	1,608,344	0.000000	0.000000	35,491	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	309,518	0.000000	0.000000	14,966	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,130,757	0.000000	0.000000	208,809	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	760,849	0.000000	0.000000	177,186	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,280,299	0.000000	0.000000	417,337	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	14,168,360	0.000000	0.000000	12,197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	764,676	0.000000	0.000000	564	92.00
200.00		Total (lines 50-199)	0	76,847,308			1,999,202	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/21/2015 10:23 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
65.01	03950	SLEEP LAB	0	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/21/2015 10:23 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	0.239420	0	1,758,675	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.652048	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.008783	0	155,474	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252855	0	1,649,350	0	0	54.00
57.00	05700	CT SCAN	0.014361	0	2,777,942	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.208183	0	594,042	0	0	58.00
60.00	06000	LABORATORY	0.150769	0	3,355,840	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.377079	0	761,671	0	0	65.00
65.01	03950	SLEEP LAB	0.320095	0	200,320	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.495360	0	501,026	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.533568	0	67,570	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.203390	0	564,275	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.532809	0	96,051	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.334782	0	1,748,763	3,190	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.209359	0	3,427,030	4,367	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.038720	0	236,100	0	0	92.00
200.00		Subtotal (see instructions)		0	17,894,129	7,557	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	17,894,129	7,557	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/21/2015 10:23 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	421,062	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	1,366	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	417,046	0		54.00
57.00	05700	CT SCAN	39,894	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	123,669	0		58.00
60.00	06000	LABORATORY	505,957	0		60.00
65.00	06500	RESPIRATORY THERAPY	287,210	0		65.00
65.01	03950	SLEEP LAB	64,121	0		65.01
66.00	06600	PHYSICAL THERAPY	248,188	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	36,053	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	114,768	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,177	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	585,454	1,068		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	717,480	914		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	245,242	0		92.00
200.00		Subtotal (see instructions)	3,858,687	1,982		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,858,687	1,982		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151301 | Component CCN: 15Z301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/21/2015 10:23 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	0.239420	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.652048	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.008783	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252855	0	0	0	0	54.00
57.00	05700	CT SCAN	0.014361	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.208183	0	0	0	0	58.00
60.00	06000	LABORATORY	0.150769	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.377079	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0.320095	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.495360	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.533568	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.203390	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.532809	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.334782	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.209359	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.038720	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: 151301 | Component CCN: 15Z301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/21/2015 10:23 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	03950	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part I Date/Time Prepared: 11/21/2015 10:23 am

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	253,016	23,769	229,247	2,064	111.07	30.00
43.00	NURSERY	12,131		12,131	539	22.51	43.00
200.00	Total (lines 30-199)	265,147		241,378	2,603		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	19	2,110				30.00
43.00	NURSERY	340	7,653				43.00
200.00	Total (lines 30-199)	359	9,763				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/21/2015 10:23 am

Title XIX | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	179,321	8,674,283	0.020673	598,489	12,373	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,595	1,804,084	0.028599	0	0	52.00
53.00	05300	ANESTHESIOLOGY	301	648,507	0.000464	25,745	12	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	108,916	6,884,535	0.015820	28,390	449	54.00
57.00	05700	CT SCAN	5,709	9,888,328	0.000577	13,572	8	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	238,305	2,084,992	0.114295	2,550	291	58.00
60.00	06000	LABORATORY	71,901	15,656,693	0.004592	299,336	1,375	60.00
65.00	06500	RESPIRATORY THERAPY	44,559	2,572,371	0.017322	147,136	2,549	65.00
65.01	03950	SLEEP LAB	9,017	610,712	0.014765	0	0	65.01
66.00	06600	PHYSICAL THERAPY	52,576	1,608,344	0.032690	3,143	103	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,068	309,518	0.022836	1,240	28	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,835	2,130,757	0.013063	2,457	32	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,262	760,849	0.010859	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,385	8,280,299	0.006810	323,961	2,206	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	119,915	14,168,360	0.008464	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	69,996	764,676	0.091537	0	0	92.00
200.00		Total (lines 50-199)	1,051,661	76,847,308		1,446,019	19,426	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part III Date/Time Prepared: 11/21/2015 10:23 am

Title XIX | Hospital | Cost

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,064	0.00	19	0		30.00
43.00	04300	NURSERY	539	0.00	340	0		43.00
200.00		Total (lines 30-199)	2,603		359	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/21/2015 10:23 am

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/21/2015 10:23 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,674,283	0.000000	0.000000	598,489	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,804,084	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	648,507	0.000000	0.000000	25,745	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,884,535	0.000000	0.000000	28,390	54.00
57.00	05700	CT SCAN	0	9,888,328	0.000000	0.000000	13,572	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,084,992	0.000000	0.000000	2,550	58.00
60.00	06000	LABORATORY	0	15,656,693	0.000000	0.000000	299,336	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,572,371	0.000000	0.000000	147,136	65.00
65.01	03950	SLEEP LAB	0	610,712	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	1,608,344	0.000000	0.000000	3,143	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	309,518	0.000000	0.000000	1,240	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,130,757	0.000000	0.000000	2,457	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	760,849	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,280,299	0.000000	0.000000	323,961	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	14,168,360	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	764,676	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	76,847,308			1,446,019	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/21/2015 10:23 am

Title XIX | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
65.01	03950	SLEEP LAB	0	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/21/2015 10:23 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)	2,318	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,064	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,493	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	107	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)	107	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	20	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)	20	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	537	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)	107	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)	107	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)	3,173,956	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	2,583	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	2,583	25.00
26.00	Total swing-bed cost (see instructions)	302,849	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,871,107	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)	2,871,107	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)	1,391.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	746,988	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)	746,988	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/21/2015 10:23 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	590,668	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,337,656	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)	148,841	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	148,841	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	297,682	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)	571	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,391.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	794,284	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/21/2015 10:23 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	253,016	2,871,107	0.088125	794,284	69,996	90.00
91.00	Nursing School cost	0	2,871,107	0.000000	794,284	0	91.00
92.00	Allied health cost	0	2,871,107	0.000000	794,284	0	92.00
93.00	All other Medical Education	0	2,871,107	0.000000	794,284	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/21/2015 10:23 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,318	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,064	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,493	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)	214	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	20	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)	20	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	19	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)	539	15.00
16.00	Nursery days (title V or XIX only)	340	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)	3,173,956	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)	298,168	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,875,788	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)	2,875,788	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)	1,393.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	26,473	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)	26,473	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/21/2015 10:23 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	500,265	539	928.14	340	315,568	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)	363,209	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	705,250	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	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)	571	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,393.31	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	795,580	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/21/2015 10:23 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	253,016	2,875,788	0.087981	795,580	69,996	90.00
91.00	Nursing School cost	0	2,875,788	0.000000	795,580	0	91.00
92.00	Allied health cost	0	2,875,788	0.000000	795,580	0	92.00
93.00	All other Medical Education	0	2,875,788	0.000000	795,580	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/21/2015 10:23 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		647,851		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.239420	412,722	98,814	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.652048	4,293	2,799	52.00
53.00	05300	ANESTHESIOLOGY	0.008783	24,487	215	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252855	27,600	6,979	54.00
57.00	05700	CT SCAN	0.014361	66,516	955	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.208183	6,823	1,420	58.00
60.00	06000	LABORATORY	0.150769	213,727	32,223	60.00
65.00	06500	RESPIRATORY THERAPY	0.377079	376,484	141,964	65.00
65.01	03950	SLEEP LAB	0.320095	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.495360	35,491	17,581	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.533568	14,966	7,985	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.203390	208,809	42,470	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.532809	177,186	94,406	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.334782	417,337	139,717	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.209359	12,197	2,554	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.038720	564	586	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,999,202	590,668	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,999,202		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151301 | Component CCN: 15Z301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/21/2015 10:23 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.239420	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.652048	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.008783	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252855	858	217	54.00
57.00	05700	CT SCAN	0.014361	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.208183	0	0	58.00
60.00	06000	LABORATORY	0.150769	864	130	60.00
65.00	06500	RESPIRATORY THERAPY	0.377079	51,726	19,505	65.00
65.01	03950	SLEEP LAB	0.320095	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.495360	53,196	26,351	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.533568	9,767	5,211	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.203390	25,807	5,249	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.532809	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.334782	72,787	24,368	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.209359	1,134	237	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.038720	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		216,139	81,268	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)		216,139		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/21/2015 10:23 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,337,760		30.00
43.00	04300	NURSERY		536,567		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.239420	598,489	143,290	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.652048	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.008783	25,745	226	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252855	28,390	7,179	54.00
57.00	05700	CT SCAN	0.014361	13,572	195	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.208183	2,550	531	58.00
60.00	06000	LABORATORY	0.150769	299,336	45,131	60.00
65.00	06500	RESPIRATORY THERAPY	0.377079	147,136	55,482	65.00
65.01	03950	SLEEP LAB	0.320095	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.495360	3,143	1,557	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.533568	1,240	662	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.203390	2,457	500	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.532809	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.334782	323,961	108,456	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.209359	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.038720	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,446,019	363,209	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)		1,446,019		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151301	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/21/2015 10:23 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,860,669	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)	3,860,669	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)	3,899,276	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)	34,802	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,895,055	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)	969,419	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)	969,419	30.00
31.00	Primary payer payments	152	31.00
32.00	Subtotal (line 30 minus line 31)	969,267	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)	810,609	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	616,063	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	479,863	36.00
37.00	Subtotal (see instructions)	1,585,330	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	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)	1,585,330	40.00
40.01	Sequestration adjustment (see instructions)	31,707	40.01
41.00	Interim payments	1,495,172	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	58,451	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: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I Date/Time Prepared: 11/21/2015 10:23 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		970,444		1,495,172	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)		970,444		1,495,172	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		187,080		58,451	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,157,524		1,553,623	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: 151301 | Component CCN: 15Z301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2015 10:23 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		348,527		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)		348,527		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		25,169		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		373,696		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: 151301 Component CCN: 15Z301	Period: From 07/01/2014 To 06/30/2015	Worksheet E-2 Date/Time Prepared: 11/21/2015 10:23 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)	300,659	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)	82,081	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	214	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)	382,740	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	382,740	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)	382,740	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,418	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)	381,322	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	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)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	381,322	0	19.00
19.01	Sequestration adjustment (see instructions)	7,626	0	19.01
20.00	Interim payments	348,527	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)	25,169	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: 151301	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part V Date/Time Prepared: 11/21/2015 10:23 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,337,656	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)	1,337,656	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,351,033	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)	1,351,033	19.00
20.00	Deductibles (exclude professional component)	204,107	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,146,926	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,146,926	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	45,027	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	34,221	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	13,395	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,181,147	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	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)	1,181,147	30.00
30.01	Sequestration adjustment (see instructions)	23,623	30.01
31.00	Interim payments	970,444	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)	187,080	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151301	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 11/21/2015 10:23 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	705,250		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	705,250	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	705,250	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	1,446,019	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,446,019	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,446,019	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	740,769	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	705,250	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	705,250	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	705,250	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	705,250	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	705,250	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	705,250	0	40.00
41.00	Interim payments	705,250	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 11/21/2015 10:23 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	7,213	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,637,387	0	0	0	4.00
5.00	Other receivable	939,472	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,292,672	0	0	0	6.00
7.00	Inventory	385,781	0	0	0	7.00
8.00	Prepaid expenses	3,985	0	0	0	8.00
9.00	Other current assets	-56,039	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,625,127	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	696,652	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	18,027,583	0	0	0	15.00
16.00	Accumulated depreciation	-7,964,389	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	431,472	0	0	0	19.00
20.00	Accumulated depreciation	-431,472	0	0	0	20.00
21.00	Automobiles and trucks	12,322	0	0	0	21.00
22.00	Accumulated depreciation	-12,322	0	0	0	22.00
23.00	Major movable equipment	5,237,611	0	0	0	23.00
24.00	Accumulated depreciation	-4,567,565	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,429,892	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	31,848,830	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	520,107	56,039	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	32,368,937	56,039	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	48,423,956	56,039	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,177,414	0	0	0	37.00
38.00	Salaries, wages, and fees payable	853,703	0	0	0	38.00
39.00	Payroll taxes payable	77,004	0	0	0	39.00
40.00	Notes and loans payable (short term)	174,042	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,088,581	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,370,744	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	13,931,418	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	54,490	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	13,985,908	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	17,356,652	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	31,067,304				52.00
53.00	Specific purpose fund		56,039			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)	31,067,304	56,039	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	48,423,956	56,039	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 11/21/2015 10:23 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		31,517,030		53,451		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,307,132				2.00
3.00	Total (sum of line 1 and line 2)		36,824,162		53,451		3.00
4.00	DEFERRED PENSION COST	-447,210		0		0	4.00
5.00	DONATIONS	15,610		8,467		0	5.00
6.00	OTHER	0		24,223		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		-431,600		32,690		10.00
11.00	Subtotal (line 3 plus line 10)		36,392,562		86,141		11.00
12.00	TRANSFERS TO AFFILIATES	5,296,059		0		0	12.00
13.00	OTHER PENSION RELATED ADJ	0		0		0	13.00
14.00	RELEASED OPERATING	0		30,102		0	14.00
15.00	RELEASED CAPITAL	29,197		0		0	15.00
16.00	ROUNDING	2		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		5,325,258		30,102		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		31,067,304		56,039		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	DEFERRED PENSION COST		0			4.00
5.00	DONATIONS		0			5.00
6.00	OTHER		0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	TRANSFERS TO AFFILIATES		0			12.00
13.00	OTHER PENSION RELATED ADJ		0			13.00
14.00	RELEASED OPERATING		0			14.00
15.00	RELEASED CAPITAL		0			15.00
16.00	ROUNDING		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: 151301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/21/2015 10:23 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,154,334		6,154,334	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,154,334		6,154,334	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,154,334		6,154,334	17.00
18.00	Ancillary services	6,937,708	52,617,865	59,555,573	18.00
19.00	Outpatient services	209,077	13,942,974	14,152,051	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		0	0	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	0	0	0	26.00
27.00	OTHER	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,301,119	66,560,839	79,861,958	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,368,816		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		21,368,816		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151301	Period: From 07/01/2014 To 06/30/2015	Worksheet G-3 Date/Time Prepared: 11/21/2015 10:23 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	79,861,958	1.00
2.00	Less contractual allowances and discounts on patients' accounts	53,139,291	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,722,667	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,368,816	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,353,851	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	958,529	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	74,948	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	0	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	139,796	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	17,428	24.00
24.01	LOSS ON INTEREST RATE SWAPS	-1,371	24.01
24.02	UNREALIZED GAINS/LOSSES	-1,266,151	24.02
24.03	NET ASSETS RELEASED FROM RESTRICTION	30,102	24.03
25.00	Total other income (sum of lines 6-24)	-46,719	25.00
26.00	Total (line 5 plus line 25)	5,307,132	26.00
27.00	LOSS ON INTEREST RATE SWAPS	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,307,132	29.00