

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: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/23/2015 4:01 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/23/2015	Time: 4:01 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARY'S WARRICK HOSPITAL, INC. (151325) 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 XVIII		HIT	Title XIX	
	Title V	Part A			
	1.00	2.00	3.00	4.00	5.00
PART III - SETTLEMENT SUMMARY					
1.00 Hospital	0	-11,010	-232,695	99,671	0 1.00
2.00 Subprovider - IPF	0	0	0	0	0 2.00
3.00 Subprovider - IRF	0	0	0	0	0 3.00
4.00 SUBPROVIDER I	0	0	0	0	0 4.00
5.00 Swing bed - SNF	0	-44,112	0	0	0 5.00
6.00 Swing bed - NF	0	0	0	0	0 6.00
200.00 Total	0	-55,122	-232,695	99,671	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-MEDI CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 151325		Period: From 07/01/2014 To 06/30/2015		Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 3:53 pm		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1116 MILLIS AVE			PO Box:				1.00			
2.00	City: BOONEVILLE			State: IN		Zip Code: 47601		County: WARRICK			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		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. MARY'S WARRICK HOSPITAL, INC.	151325	21780	1	03/01/2005	N	O	O	3.00
4.00	Subprovider - IPF		SERENITY PSYCH UNIT	15M325	21780	4	03/01/2005	N	P	O	4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		ST. MARY'S WARRICK - SWING BED	15Z325	21780		03/01/2005	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	0	25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 3:53 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		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	XVII	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		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		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		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N		N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					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

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	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		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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		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
				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.			Y		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
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
				1.00	2.00	3.00
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.				N	87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	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	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	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. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	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 1.00	Occupational 2.00	Speech 3.00	Respiratory 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 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	87,822	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: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 3:53 pm		
		1.00	2.00			
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	158056	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. MARY'S HEALTH	Contractor's Name: WPS		Contractor's Number: 08101		
142.00	Street: 3700 WASHINGTON AVE.	PO Box:				
143.00	City: EVANSVILLE	State: IN		Zip Code: 47550		
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?	Y			144.00	
				1.00		
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	
156.00	Subprovider - IPF	N	N	N	N	
157.00	Subprovider - IRF	N	N	N	N	
158.00	SUBPROVIDER					
159.00	SNF	N	N	N	N	
160.00	HOME HEALTH AGENCY	N	N	N	N	
161.00	CMHC		N	N	N	
				1.00		
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N			165.00	
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
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
				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.	Y			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)	104,259			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	
				1.00		
				1.00		
				2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2013		09/30/2014		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-2
Part I
Date/Time Prepared:
11/23/2015 3:53 pm

		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: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/23/2015 3:53 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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	10/08/2015	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: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/23/2015 3:53 pm	
	Description	Part A		Part B	
		Y/N	Date	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 relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL		HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3519		JILL.HILL@STVINCENT.ORG	43.00

		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)	10/08/2015		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: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
11/23/2015 3:53 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	22,536.00	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	22,536.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	22,536.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		35				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: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
11/23/2015 3:53 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	652	42	939			1.00
2.00 HMO and other (see instructions)	61	27				2.00
3.00 HMO IPF Subprovider	488	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	1,188	0	1,188			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	1,134			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,840	42	3,261			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	1,840	42	3,261	0.00	81.20	14.00
15.00 CAH visits	7,812	3,998	20,644			15.00
16.00 SUBPROVIDER - IPF	2,940	0	3,577	0.00	18.85	16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	100.05	27.00
28.00 Observation Bed Days		0	355			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			14			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
11/23/2015 3:53 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	150	11	236	1.00
2.00 HMO and other (see instructions)			16	7		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	150	11	236	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	223	0	272	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet S-10 Date/Time Prepared: 11/23/2015 3:53 pm
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			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)		0.372229	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		5,012,837	6.00
7.00	Medicaid cost (line 1 times line 6)		1,865,923	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)		1,865,923	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)		1,865,923	19.00
			1.00	
			1.00	
			2.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	Uninsured patients	534,803	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	Insured patients	259,098	21.00
22.00	Partial payment by patients approved for charity care		96,444	22.00
23.00	Cost of charity care (line 21 minus line 22)		295,513	23.00
			0	
			0	
			199,069	
			96,444	
			295,513	
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,980,505	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		229,217	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		1,751,288	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		651,880	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		947,393	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,813,316	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet A
Date/Time Prepared:
11/23/2015 3:53 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		26,753	26,753	0	26,753	1.00
2.00	00200		166,088	166,088	0	166,088	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	135,827	1,127,551	1,263,378	0	1,263,378	4.00
5.01	00540	0	23,052	23,052	0	23,052	5.01
5.02	00560	0	21,404	21,404	0	21,404	5.02
5.03	00580	313,108	495,245	808,353	0	808,353	5.03
5.04	00590	513,175	1,894,970	2,408,145	-200,075	2,208,070	5.04
6.00	00600	0	0	0	0	0	6.00
7.00	00700	50,467	1,376,758	1,427,225	0	1,427,225	7.00
8.00	00800	0	40,720	40,720	0	40,720	8.00
9.00	00900	0	203,867	203,867	0	203,867	9.00
10.00	01000	8,262	356,089	364,351	-50,395	313,956	10.00
11.00	01100	0	0	0	50,395	50,395	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	200,075	200,075	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	220,189	29,517	249,706	0	249,706	15.00
16.00	01600	53,976	54,605	108,581	0	108,581	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	955,312	148,554	1,103,866	0	1,103,866	30.00
31.00	03100	0	0	0	0	0	31.00
40.00	04000	848,268	486,113	1,334,381	0	1,334,381	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	164,586	382,975	547,561	-47,544	500,017	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	271,586	271,586	0	271,586	53.00
54.00	05400	361,132	136,933	498,065	0	498,065	54.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	373,496	392,255	765,751	0	765,751	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	104,651	20,297	124,948	0	124,948	65.00
66.00	06600	278,621	22,355	300,976	0	300,976	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	1,045	1,045	69.00
71.00	07100	0	15,874	15,874	47,544	63,418	71.00
72.00	07200	0	5,062	5,062	0	5,062	72.00
73.00	07300	0	346,320	346,320	0	346,320	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	531,019	1,667,357	2,198,376	0	2,198,376	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		4,912,089	9,712,300	14,624,389	1,045	14,625,434	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	1,045	12,845	13,890	-1,045	12,845	194.00
194.01	07951	69,012	17,768	86,780	0	86,780	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00		4,982,146	9,742,913	14,725,059	0	14,725,059	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet A
Date/Time Prepared:
11/23/2015 3:53 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,851	30,604	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-79,119	86,969	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	312,454	1,575,832	4.00
5.01	00540	NONPATIENT TELEPHONES	-816	22,236	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	21,404	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	-74,602	733,751	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	722,402	2,930,472	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-118,724	1,308,501	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	40,720	8.00
9.00	00900	HOUSEKEEPING	-8,040	195,827	9.00
10.00	01000	DIETARY	-38,984	274,972	10.00
11.00	01100	CAFETERIA	0	50,395	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	200,075	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	249,706	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	108,581	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,103,866	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
40.00	04000	SUBPROVIDER - I PF	-4,495	1,329,886	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-158,712	341,305	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-261,200	10,386	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	498,065	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-110	765,641	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-2,880	122,068	65.00
66.00	06600	PHYSICAL THERAPY	-18,269	282,707	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,045	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	63,418	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,062	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	346,320	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-408,134	1,790,242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-135,378	14,490,056	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	12,845	194.00
194.01	07951	OTHER NRCC - JAIL	0	86,780	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-135,378	14,589,681	200.00

RECLASSIFICATIONS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6

Date/Time Prepared:
11/23/2015 3:53 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - NURSING ADMIN SALARIES					
1.00	NURSING ADMINISTRATION	13.00	200,075	0	1.00
	TOTALS		200,075	0	
B - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	0	49,252	1.00
2.00	CAFETERIA	11.00	1,143	0	2.00
	TOTALS		1,143	49,252	
C - CLINIC					
1.00	ELECTROCARDIOLOGY	69.00	0	1,045	1.00
	TOTALS		0	1,045	
D - SUPPLIES AND IMPLANTABLE DEVICES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	47,544	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	90	2.00
	TOTALS		0	47,634	
E - BENEFITS SAL TO OTHER					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	135,590	1.00
	TOTALS		0	135,590	
500.00	Grand Total: Increases		201,218	233,521	500.00

RECLASSIFICATIONS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6

Date/Time Prepared:
11/23/2015 3:53 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - NURSING ADMIN SALARIES							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	200,075	0	0		1.00
	TOTALS		200,075	0			
B - CAFETERIA EXPENSE							
1.00	DIETARY	10.00	0	49,252	0		1.00
2.00	DIETARY	10.00	1,143	0	0		2.00
	TOTALS		1,143	49,252			
C - CLINIC							
1.00	OTHER NRCC - PHYSICIAN CLINIC	194.00	1,045	0	0		1.00
	TOTALS		1,045	0			
D - SUPPLIES AND IMPLANTABLE DEVICES							
1.00	OPERATING ROOM	50.00	0	47,544	0		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	90	0		2.00
	TOTALS		0	47,634			
E - BENEFITS SAL TO OTHER							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	135,590	0	0		1.00
	TOTALS		135,590	0			
500.00	Grand Total: Decreases		337,853	96,886			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-7
Part I
Date/Time Prepared:
11/23/2015 3:53 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	445,242	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,597,087	51,812	0	51,812	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	7,786,677	238,394	0	238,394	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,829,006	290,206	0	290,206	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	19,829,006	290,206	0	290,206	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	445,242	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	11,648,899	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	8,025,071	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	20,119,212	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	20,119,212	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-7
Part II
Date/Time Prepared:
11/23/2015 3:53 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	26,753	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	14,720	150,599	769	0	2.00
3.00	Total (sum of lines 1-2)	0	14,720	150,599	27,522	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	26,753				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	166,088				2.00
3.00	Total (sum of lines 1-2)	0	192,841				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-7
Part III
Date/Time Prepared:
11/23/2015 3:53 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	11,648,899	0	11,648,899	0.592097	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,025,071	0	8,025,071	0.407903	0	2.00
3.00	Total (sum of lines 1-2)	19,673,970	0	19,673,970	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	12,127	14,720	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,127	14,720	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col.s. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	26,753	0	3,851	30,604	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	59,353	769	0	0	86,969	2.00
3.00	Total (sum of lines 1-2)	59,353	27,522	0	3,851	117,573	3.00

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)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)	B	-69	0	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-830,926				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	1,425,771				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-37,139	0	DIETARY	10.00	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	B	-1,845	0	DIETARY	10.00	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	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-73,194	0	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	32.00
33.00 OTHER EXERCISE REVENUE	B	-18,269	0	PHYSICAL THERAPY	66.00	0	33.00
33.01 OTHER HOUSEKEEPING REVENUE	B	-8,040	0	HOUSEKEEPING	9.00	0	33.01

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.02 BUILDING RENTAL INCOME	B	-15,873	OPERATION OF PLANT		7.00	0 33.02
33.03 INCOME GENESIS	B	-4,942	OTHER ADMINISTRATIVE AND GENERAL		5.04	0 33.03
33.04 PENSION ADJUSTMENT	A	312,454	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.04
33.05 OTHER ADMIN REVENUE	B	402	OTHER ADMINISTRATIVE AND GENERAL		5.04	0 33.05
33.06 OTHER PLANT OPS REVENUE	B	-600	OPERATION OF PLANT		7.00	0 33.06
33.07 OTHER LAB REVENUE	B	-110	LABORATORY		60.00	0 33.07
33.08 INVESTMENT REVENUE	B	-17,648	CAP REL COSTS-MVBLE EQUIP		2.00	11 33.08
33.09 PHYSICIAN BILLING COSTS	A	-1,408	CASHIERING/ACCOUNTS RECEIVABLE		5.03	0 33.09
33.10		0			0.00	0 33.10
33.11 UNNECESSARY BORROWING	A	-73,598	CAP REL COSTS-MVBLE EQUIP		2.00	11 33.11
33.12		0			0.00	0 33.12
33.13 TELEPHONE SERVICES	A	-816	NONPATIENT TELEPHONES		5.01	0 33.13
33.14		0			0.00	0 33.14
33.15 NON-ALLOWABLE COMMUNITY PROJECTS	A	-4,297	OTHER ADMINISTRATIVE AND GENERAL		5.04	0 33.15
33.16		0			0.00	0 33.16
33.17		0			0.00	0 33.17
33.18 AHA LOBBYING	A	-521	OTHER ADMINISTRATIVE AND GENERAL		5.04	0 33.18
33.19 NON-ALLOWABLE CED SALARIES	A	-4,495	SUBPROVIDER - IPF		40.00	0 33.19
33.20		0			0.00	0 33.20
33.21 PROVIDER TAX ADJUSTMENT	A	-780,215	OTHER ADMINISTRATIVE AND GENERAL		5.04	0 33.21
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-135,378				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: 151325

Period: From 07/01/2014 To 06/30/2015

Worksheet A-8-1

Date/Time Prepared: 11/23/2015 3:53 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.04	OTHER ADMINISTRATIVE AND GEN	SMHS CAPITAL	86,433	0
2.00	5.04	OTHER ADMINISTRATIVE AND GEN	SMHS NON-CAPITAL	2,384,541	0
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	ASCENSION BOND AMORTIZATION	89,128	77,001
4.00	0.00			0	0
4.01	5.04	OTHER ADMINISTRATIVE AND GEN	MISSION HEALTH FEE	0	958,930
4.02	0.00			0	0
4.03	0.00			0	0
4.04	0.00			0	0
4.05	0.00			0	0
4.06	1.00	CAP REL COSTS-BLDG & FIXT	PASS THROUGH	37,910	37,910
4.07	2.00	CAP REL COSTS-MVBLE EQUIP	PASS THROUGH	141,250	141,250
4.08	4.00	EMPLOYEE BENEFITS DEPARTMENT	PASS THROUGH	1,224,032	1,224,032
4.09	5.01	NONPATIENT TELEPHONES	PASS THROUGH	1,021	1,021
4.10	5.03	CASHIERING/ACCOUNTS RECEIVAB	PASS THROUGH	391	391
4.11	5.04	OTHER ADMINISTRATIVE AND GEN	PASS THROUGH	10,169	10,169
4.12	7.00	OPERATION OF PLANT	PASS THROUGH	305,820	305,820
4.13	8.00	LAUNDRY & LINEN SERVICE	PASS THROUGH	30,676	30,676
4.14	15.00	PHARMACY	PASS THROUGH	33,712	33,712
4.15	16.00	MEDICAL RECORDS & LIBRARY	PASS THROUGH	10,982	10,982
4.16	50.00	OPERATING ROOM	PASS THROUGH	8,231	8,231
4.17	54.00	RADIOLOGY-DIAGNOSTIC	PASS THROUGH	10,853	10,853
4.18	60.00	LABORATORY	PASS THROUGH	57,497	57,497
4.19	65.00	RESPIRATORY THERAPY	PASS THROUGH	1,800	1,800
4.20	66.00	PHYSICAL THERAPY	PASS THROUGH	379	379
4.21	71.00	MEDICAL SUPPLIES CHARGED TO	PASS THROUGH	555	555
4.22	0.00			0	0
4.23	1.00	CAP REL COSTS-BLDG & FIXT	TRIMEDX	3,851	0
4.24	7.00	OPERATION OF PLANT	TRIMEDX	427,409	529,660
5.00	0			4,866,640	3,440,869

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

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

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

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

6.00	B	0.00	ST. MARY'S HEAL	100.00	6.00
7.00	B	0.00	ASCENSION	100.00	7.00
8.00	A	0.00	TRIMEDX	0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				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: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8-1

Date/Time Prepared:
11/23/2015 3:53 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	86,433	0		1.00
2.00	2,384,541	0		2.00
3.00	12,127	9		3.00
4.00	0	0		4.00
4.01	-958,930	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	12		4.06
4.07	0	11		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.23	3,851	14		4.23
4.24	-102,251	0		4.24
5.00	1,425,771			5.00

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

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	ADMINISTRATION		7.00
8.00	TECHNOLOGY MGMT		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8-2

Date/Time Prepared:
11/23/2015 3:53 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,316,561	408,134	908,427	0	0	1.00
2.00	50.00	OPERATING ROOM	158,712	158,712	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	261,200	261,200	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	2,880	2,880	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,739,353	830,926	908,427	0	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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	91.00	EMERGENCY	0	0	0	408,134	1.00
2.00	50.00	OPERATING ROOM	0	0	0	158,712	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	261,200	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	2,880	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	830,926	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part I
Date/Time Prepared:
11/23/2015 3:53 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	30,604	30,604			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	86,969		86,969		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,575,832	289	822	1,576,943	4.00
5.01 00540	NONPATIENT TELEPHONES	22,236	132	374	0	22,742 5.01
5.02 00560	PURCHASING RECEIVING AND STORES	21,404	544	1,545	0	0 5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	733,751	972	2,764	101,904	2,474 5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	2,930,472	3,923	11,149	101,902	4,473 5.04
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	1,308,501	2,226	6,325	16,425	952 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	40,720	228	647	0	190 8.00
9.00 00900	HOUSEKEEPING	195,827	554	1,574	0	95 9.00
10.00 01000	DIETARY	274,972	1,293	3,674	2,317	381 10.00
11.00 01100	CAFETERIA	50,395	470	1,337	372	95 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	200,075	108	306	65,116	190 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	351	996	0	95 14.00
15.00 01500	PHARMACY	249,706	495	1,407	71,663	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	108,581	735	2,088	17,567	1,618 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,103,866	3,839	10,910	310,916	1,332 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
40.00 04000	SUBPROVIDER - IPF	1,329,886	2,734	7,769	276,077	1,047 40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	341,305	2,380	6,764	53,566	1,332 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	10,386	36	104	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	498,065	1,854	5,269	117,534	1,522 54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	765,641	883	2,508	121,558	952 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	122,068	260	739	34,060	571 65.00
66.00 06600	PHYSICAL THERAPY	282,707	1,869	5,311	90,680	856 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	1,045	85	241	0	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	63,418	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,062	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	346,320	0	0	0	476 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	1,790,242	1,436	4,081	172,825	856 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,490,056	27,696	78,704	1,554,482	19,507 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	175	497	0	95 190.00
194.00 07950	OTHER NRCC - PHYSICIAN CLINIC	12,845	1,668	4,741	0	3,140 194.00
194.01 07951	OTHER NRCC - JAIL	86,780	0	0	22,461	0 194.01
194.02 07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0 194.02
194.03 07953	OTHER NRCC - DR. OFFICE	0	1,065	3,027	0	0 194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	14,589,681	30,604	86,969	1,576,943	22,742 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part I
Date/Time Prepared:
11/23/2015 3:53 pm

Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	23,493					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	841,865				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,340	0	3,053,259	3,053,259		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	7,593	0	1,342,022	355,184		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	41,785	11,059	0	8.00
9.00	00900	HOUSEKEEPING	832	0	198,882	52,637	0	9.00
10.00	01000	DIETARY	0	0	282,637	74,804	0	10.00
11.00	01100	CAFETERIA	0	0	52,669	13,940	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	265,795	70,346	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,442	382	0	14.00
15.00	01500	PHARMACY	0	0	323,271	85,558	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	130,589	34,562	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,097	59,865	1,495,825	395,890	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	5,708	111,098	1,734,319	459,010	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	290	29,415	435,052	115,142	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	5,005	15,531	4,110	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	208	131,199	755,651	199,993	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	44	100,393	991,979	262,540	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	28	13,897	171,623	45,422	0	65.00
66.00	06600	PHYSICAL THERAPY	1,047	56,674	439,144	116,225	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,775	11,146	2,950	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	30,763	94,181	24,926	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,837	7,899	2,091	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	71,957	418,753	110,828	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,306	218,987	2,189,733	579,535	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,493	841,865	14,453,187	3,017,134	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	767	203	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	0	22,394	5,927	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	109,241	28,912	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	4,092	1,083	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	23,493	841,865	14,589,681	3,053,259	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	1,697,206				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,164	70,008			8.00
9.00	00900	HOUSEKEEPING	41,749	6,772	300,040		9.00
10.00	01000	DIETARY	97,455	0	0	454,896	10.00
11.00	01100	CAFETERIA	35,458	0	6,650	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	108,717	12.00
13.00	01300	NURSING ADMINISTRATION	8,124	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26,418	0	0	0	14.00
15.00	01500	PHARMACY	37,321	0	8,221	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,370	0	3,108	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	289,371	16,051	89,131	309,958	31,373
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
40.00	04000	SUBPROVIDER - I/PF	206,058	15,461	82,412	144,938	26,135
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	179,396	5,441	6,316	0	4,638
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	2,749	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,754	8,661	11,998	0	9,337
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	66,518	0	9,324	0	11,388
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	19,607	0	6,617	0	2,784
66.00	06600	PHYSICAL THERAPY	140,854	2,955	0	0	5,833
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	6,383	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	108,236	14,667	40,772	0	11,597
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,477,985	70,008	264,549	454,896	108,717
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,194	0	2,139	0	0
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	125,736	0	23,761	0	0
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0
194.03	07953	OTHER NRCC - DR. OFFICE	80,291	0	9,591	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,697,206	70,008	300,040	454,896	108,717

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

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Cost Center Description			MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	344,265				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	28,242			14.00
15.00	01500	PHARMACY	0	0	0	457,096		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	226,536	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	104,771	0	2,624	16,109	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	87,278	0	340	29,895	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	15,488	0	2,105	7,915	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	778	1,347	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,181	0	7,213	35,303	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	38,032	0	94	27,014	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	9,298	0	80	3,740	65.00
66.00	06600	PHYSICAL THERAPY	0	19,479	0	70	15,250	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	2,630	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	28,242	0	8,278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	763	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	442,075	19,362	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	38,729	0	1,717	58,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	344,256	28,242	457,096	226,536	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	9	0	0	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	344,265	28,242	457,096	226,536	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.01	00540					5.01
5.02	00560					5.02
5.03	00580					5.03
5.04	00590					5.04
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
12.00	01200					12.00
13.00	01300					13.00
14.00	01400					14.00
15.00	01500					15.00
16.00	01600					16.00
17.00	01700					17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	0	2,751,103	0	2,751,103	30.00
31.00	03100	0	0	0	0	31.00
40.00	04000	0	2,785,846	0	2,785,846	40.00
41.00	04100	0	0	0	0	41.00
42.00	04200	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	771,493	0	771,493	50.00
51.00	05100	0	0	0	0	51.00
52.00	05200	0	0	0	0	52.00
53.00	05300	0	24,515	0	24,515	53.00
54.00	05400	0	1,199,091	0	1,199,091	54.00
56.00	05600	0	0	0	0	56.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
59.00	05900	0	0	0	0	59.00
60.00	06000	0	1,406,889	0	1,406,889	60.00
60.01	06001	0	0	0	0	60.01
63.00	06300	0	0	0	0	63.00
64.00	06400	0	0	0	0	64.00
65.00	06500	0	259,171	0	259,171	65.00
66.00	06600	0	739,810	0	739,810	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
69.00	06900	0	23,109	0	23,109	69.00
71.00	07100	0	155,627	0	155,627	71.00
72.00	07200	0	10,753	0	10,753	72.00
73.00	07300	0	991,018	0	991,018	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	0	0	0	0	90.00
91.00	09100	0	3,043,916	0	3,043,916	91.00
92.00	09200	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00		0	14,162,341	0	14,162,341	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	16,303	0	16,303	190.00
194.00	07950	0	177,827	0	177,827	194.00
194.01	07951	0	138,153	0	138,153	194.01
194.02	07952	0	0	0	0	194.02
194.03	07953	0	95,057	0	95,057	194.03
200.00		0	0	0	0	200.00
201.00		0	0	0	0	201.00
202.00		0	14,589,681	0	14,589,681	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS				Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00			
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	289	822	1,111	1,111	4.00
5.01 00540	NONPATIENT TELEPHONES	1,233	132	374	1,739	0	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	0	544	1,545	2,089	0	5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	85,683	972	2,764	89,419	72	5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	87,177	3,923	11,149	102,249	72	5.04
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	384,663	2,226	6,325	393,214	12	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	228	647	875	0	8.00
9.00 00900	HOUSEKEEPING	0	554	1,574	2,128	0	9.00
10.00 01000	DIETARY	4,486	1,293	3,674	9,453	2	10.00
11.00 01100	CAFETERIA	0	470	1,337	1,807	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	108	306	414	46	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	351	996	1,347	0	14.00
15.00 01500	PHARMACY	1,289	495	1,407	3,191	50	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	735	2,088	2,823	12	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	38,665	3,839	10,910	53,414	218	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00 04000	SUBPROVIDER - IPF	16,858	2,734	7,769	27,361	194	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	57,948	2,380	6,764	67,092	38	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	9,771	36	104	9,911	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	12,077	1,854	5,269	19,200	83	54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	21,551	883	2,508	24,942	86	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	4,645	260	739	5,644	24	65.00
66.00 06600	PHYSICAL THERAPY	4,389	1,869	5,311	11,569	64	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	85	241	326	0	69.00
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							
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	5,884	1,436	4,081	11,401	122	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	736,319	27,696	78,704	842,719	1,095	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	175	497	672	0	190.00
194.00 07950	OTHER NRCC - PHYSICIAN CLINIC	10,094	1,668	4,741	16,503	0	194.00
194.01 07951	OTHER NRCC - JAIL	0	0	0	0	16	194.01
194.02 07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03 07953	OTHER NRCC - DR. OFFICE	0	1,065	3,027	4,092	0	194.03
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers				0	0	201.00
202.00	TOTAL (sum lines 118-201)	746,413	30,604	86,969	863,986	1,111	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151325

Period: From 07/01/2014 To 06/30/2015

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Cost Center Description		NONPATIENT TELEPHONES	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
		5.01	5.02	5.03	5.04	6.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540	1,739					5.01
5.02	00560	0	2,089				5.02
5.03	00580	189	0	89,680			5.03
5.04	00590	343	119	0	102,783		5.04
6.00	00600	0	0	0	0	0	6.00
7.00	00700	73	675	0	11,956	0	7.00
8.00	00800	15	0	0	372	0	8.00
9.00	00900	7	74	0	1,772	0	9.00
10.00	01000	29	0	0	2,518	0	10.00
11.00	01100	7	0	0	469	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	15	0	0	2,368	0	13.00
14.00	01400	7	0	0	13	0	14.00
15.00	01500	0	0	0	2,880	0	15.00
16.00	01600	124	0	0	1,163	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	102	453	6,377	13,326	0	30.00
31.00	03100	0	0	0	0	0	31.00
40.00	04000	80	508	11,834	15,451	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	102	26	3,133	3,876	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	533	138	0	53.00
54.00	05400	116	18	13,976	6,732	0	54.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	73	4	10,694	8,838	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	44	3	1,480	1,529	0	65.00
66.00	06600	65	93	6,037	3,912	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	1,041	99	0	69.00
71.00	07100	0	0	3,277	839	0	71.00
72.00	07200	0	0	302	70	0	72.00
73.00	07300	36	0	7,665	3,731	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	65	116	23,331	19,515	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		1,492	2,089	89,680	101,567	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	7	0	0	7	0	190.00
194.00	07950	240	0	0	200	0	194.00
194.01	07951	0	0	0	973	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	36	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,739	2,089	89,680	102,783	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part II
Date/Time Prepared:
11/23/2015 3:53 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	405,930				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,105	5,367			8.00
9.00	00900	HOUSEKEEPING	9,985	519	14,485		9.00
10.00	01000	DIETARY	23,309	0	0	35,311	10.00
11.00	01100	CAFETERIA	8,481	0	321	0	11,085
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,943	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,318	0	0	0	14.00
15.00	01500	PHARMACY	8,926	0	397	0	278
16.00	01600	MEDICAL RECORDS & LIBRARY	13,243	0	150	0	296
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	69,211	1,231	4,304	24,060	3,199
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
40.00	04000	SUBPROVIDER - IPF	49,284	1,185	3,979	11,251	2,665
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	42,907	417	305	0	473
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	657	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,426	664	579	0	952
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	15,909	0	450	0	1,161
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	4,690	0	319	0	284
66.00	06600	PHYSICAL THERAPY	33,689	227	0	0	595
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	1,527	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	25,887	1,124	1,968	0	1,182
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	353,497	5,367	12,772	35,311	11,085
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,156	0	103	0	0
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	30,073	0	1,147	0	0
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0
194.03	07953	OTHER NRCC - DR. OFFICE	19,204	0	463	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	405,930	5,367	14,485	35,311	11,085

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part II
Date/Time Prepared:
11/23/2015 3:53 pm

Cost Center Description		MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00560						5.02
5.03	00580						5.03
5.04	00590						5.04
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200	0					12.00
13.00	01300	0	4,786				13.00
14.00	01400	0	0	7,685			14.00
15.00	01500	0	0	0	15,722		15.00
16.00	01600	0	0	0	0	17,811	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	1,458	0	90	1,266	30.00
31.00	03100	0	0	0	0	0	31.00
40.00	04000	0	1,213	0	12	2,350	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	215	0	72	622	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	27	106	53.00
54.00	05400	0	433	0	248	2,775	54.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	529	0	3	2,123	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	129	0	3	294	65.00
66.00	06600	0	271	0	2	1,199	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	207	69.00
71.00	07100	0	0	7,685	0	651	71.00
72.00	07200	0	0	0	0	60	72.00
73.00	07300	0	0	0	15,206	1,522	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	538	0	59	4,636	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		0	4,786	7,685	15,722	17,811	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		0	4,786	7,685	15,722	17,811	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part II
Date/Time Prepared:
11/23/2015 3:53 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	178,709	0	178,709	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - I PF	0	127,367	0	127,367	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	119,278	0	119,278	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	11,372	0	11,372	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	79,202	0	79,202	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	64,812	0	64,812	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	14,443	0	14,443	65.00
66.00	06600	PHYSICAL THERAPY	0	57,723	0	57,723	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,200	0	3,200	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,452	0	12,452	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	432	0	432	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,160	0	28,160	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	89,944	0	89,944	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	787,094	0	787,094	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,945	0	3,945	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	48,163	0	48,163	194.00
194.01	07951	OTHER NRCC - JAIL	0	989	0	989	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	23,795	0	23,795	194.03
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	863,986	0	863,986	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1

Date/Time Prepared:
11/23/2015 3:53 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NONPATIENT TELEPHONES)	PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	75,527				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		75,527			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	714	714	4,845,274		4.00
5.01 00540	NONPATIENT TELEPHONES	325	325	0	239	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	1,342	1,342	0	0	9,153 5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	2,400	2,400	313,108	26	0 5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	9,681	9,681	313,100	47	522 5.04
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	5,493	5,493	50,467	10	2,958 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	562	562	0	2	0 8.00
9.00 00900	HOUSEKEEPING	1,367	1,367	0	1	324 9.00
10.00 01000	DIETARY	3,191	3,191	7,119	4	0 10.00
11.00 01100	CAFETERIA	1,161	1,161	1,143	1	0 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	266	266	200,075	2	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	865	865	0	1	0 14.00
15.00 01500	PHARMACY	1,222	1,222	220,189	0	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,813	1,813	53,976	17	0 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	9,475	9,475	955,312	14	1,986 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
40.00 04000	SUBPROVIDER - IPF	6,747	6,747	848,268	11	2,224 40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,874	5,874	164,586	14	113 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	90	90	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,576	4,576	361,132	16	81 54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	2,178	2,178	373,496	10	17 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	642	642	104,651	6	11 65.00
66.00 06600	PHYSICAL THERAPY	4,612	4,612	278,621	9	408 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	209	209	0	0	0 69.00
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	5	0 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	3,544	3,544	531,019	9	509 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	68,349	68,349	4,776,262	205	9,153 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	432	432	0	1	0 190.00
194.00 07950	OTHER NRCC - PHYSICIAN CLINIC	4,117	4,117	0	33	0 194.00
194.01 07951	OTHER NRCC - JAIL	0	0	69,012	0	0 194.01
194.02 07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0 194.02
194.03 07953	OTHER NRCC - DR. OFFICE	2,629	2,629	0	0	0 194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	30,604	86,969	1,576,943	22,742	23,493 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.405206	1.151495	0.325460	95.154812	2.566699 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			1,111	1,739	2,089 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000229	7.276151	0.228231 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1
Date/Time Prepared:
11/23/2015 3:53 pm

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (ASSIGNED TIME)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5A.04	5.04	6.00	7.00	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	38,047,359					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	-3,053,259	11,536,422			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	0	1,342,022	0	55,572	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	41,785	0	562	8.00
9.00	00900	HOUSEKEEPING	0	0	198,882	0	1,367	9.00
10.00	01000	DIETARY	0	0	282,637	0	3,191	10.00
11.00	01100	CAFETERIA	0	0	52,669	0	1,161	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	265,795	0	266	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,442	0	865	14.00
15.00	01500	PHARMACY	0	0	323,271	0	1,222	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	130,589	0	1,813	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,705,522	0	1,495,825	0	9,475	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - I PF	5,020,931	0	1,734,319	0	6,747	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,329,378	0	435,052	0	5,874	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	226,188	0	15,531	0	90	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,929,375	0	755,651	0	4,576	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,537,134	0	991,979	0	2,178	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	628,078	0	171,623	0	642	65.00
66.00	06600	PHYSICAL THERAPY	2,561,307	0	439,144	0	4,612	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	441,753	0	11,146	0	209	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,390,293	0	94,181	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	128,213	0	7,899	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,251,990	0	418,753	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	9,897,197	0	2,189,733	0	3,544	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	38,047,359	-3,053,259	11,399,928	0	48,394	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	767	0	432	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	0	22,394	0	4,117	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	109,241	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	4,092	0	2,629	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	841,865		3,053,259	0	1,697,206	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.022127		0.264663	0.000000	30.540668	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	89,680		102,783	0	405,930	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002357		0.008909	0.000000	7.304578	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1

Date/Time Prepared:
11/23/2015 3:53 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (MINUTES OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	
		8.00	9.00	10.00	11.00	12.00	
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
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,460				8.00
9.00	00900	HOUSEKEEPING	1,689	44,890			9.00
10.00	01000	DIETARY	0	0	32,867		10.00
11.00	01100	CAFETERIA	0	995	0	163,108	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	1,230	0	4,089	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	465	0	4,361	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,003	13,335	22,395	47,069	0
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
40.00	04000	SUBPROVIDER - I/PF	3,856	12,330	10,472	39,210	0
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,357	945	0	6,958	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,160	1,795	0	14,008	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	1,395	0	17,086	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	990	0	4,177	0
66.00	06600	PHYSICAL THERAPY	737	0	0	8,751	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	3,658	6,100	0	17,399	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,460	39,580	32,867	163,108	0
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	320	0	0	0
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	3,555	0	0	0
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0
194.03	07953	OTHER NRCC - DR. OFFICE	0	1,435	0	0	0
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)	70,008	300,040	454,896	108,717	0
203.00		Unit cost multiplier (Wkst. B, Part I)	4.009622	6.683894	13.840509	0.666534	0.000000
204.00		Cost to be allocated (per Wkst. B, Part II)	5,367	14,485	35,311	11,085	0
205.00		Unit cost multiplier (Wkst. B, Part II)	0.307388	0.322678	1.074360	0.067961	0.000000

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1
Date/Time Prepared:
11/23/2015 3:53 pm

Cost Center Description			NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION	154,662					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100				14.00
15.00	01500	PHARMACY	0	0	361,284			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	38,047,359		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	47,069	0	2,074	2,705,522	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	39,210	0	269	5,020,931	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,958	0	1,664	1,329,378	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	615	226,188	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,008	0	5,701	5,929,375	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	17,086	0	74	4,537,134	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,177	0	63	628,078	0	65.00
66.00	06600	PHYSICAL THERAPY	8,751	0	55	2,561,307	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	441,753	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100	0	1,390,293	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	128,213	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	349,412	3,251,990	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	17,399	0	1,357	9,897,197	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	154,658	100	361,284	38,047,359	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	4	0	0	0	0	194.00
194.01	07951	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	344,265	28,242	457,096	226,536	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.225918	282.420000	1.265199	0.005954	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,786	7,685	15,722	17,811	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.030945	76.850000	0.043517	0.000468	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet C
Part I
Date/Time Prepared:
11/23/2015 3:53 pm

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2,751,103		2,751,103	0	2,751,103 30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0 31.00
40.00	04000 SUBPROVIDER - I/PF	2,785,846		2,785,846	0	2,785,846 40.00
41.00	04100 SUBPROVIDER - I/RF	0		0	0	0 41.00
42.00	04200 SUBPROVIDER	0		0	0	0 42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	771,493		771,493	0	771,493 50.00
51.00	05100 RECOVERY ROOM	0		0	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	24,515		24,515	0	24,515 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,199,091		1,199,091	0	1,199,091 54.00
56.00	05600 RADIOISOTOPE	0		0	0	0 56.00
57.00	05700 CT SCAN	0		0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	06000 LABORATORY	1,406,889		1,406,889	0	1,406,889 60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0 60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0 63.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	259,171	0	259,171	0	259,171 65.00
66.00	06600 PHYSICAL THERAPY	739,810	0	739,810	0	739,810 66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	23,109		23,109	0	23,109 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	155,627		155,627	0	155,627 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10,753		10,753	0	10,753 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	991,018		991,018	0	991,018 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0		0	0	0 90.00
91.00	09100 EMERGENCY	3,043,916		3,043,916	0	3,043,916 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	372,544		372,544	0	372,544 92.00
200.00	Subtotal (see instructions)	14,534,885	0	14,534,885	0	14,534,885 200.00
201.00	Less Observation Beds	372,544		372,544	0	372,544 201.00
202.00	Total (see instructions)	14,162,341	0	14,162,341	0	14,162,341 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet C
Part I
Date/Time Prepared:
11/23/2015 3:53 pm

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,434,196		2,434,196		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
40.00	04000	SUBPROVIDER - IPF	5,020,931		5,020,931		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	165,757	1,163,621	1,329,378	0.580341	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	19,215	206,973	226,188	0.108383	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,296,063	4,633,312	5,929,375	0.202229	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	988,067	3,549,067	4,537,134	0.310083	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	317,436	310,642	628,078	0.412641	65.00
66.00	06600	PHYSICAL THERAPY	1,122,065	1,439,242	2,561,307	0.288841	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	169,516	272,237	441,753	0.052312	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	505,968	884,325	1,390,293	0.111938	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	128,213	128,213	0.083868	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,954,421	1,297,569	3,251,990	0.304742	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	2,838,325	7,058,872	9,897,197	0.307553	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	271,326	271,326	1.373049	92.00
200.00		Subtotal (see instructions)	16,831,960	21,215,399	38,047,359		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	16,831,960	21,215,399	38,047,359		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/23/2015 3:53 pm
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.580341		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.108383		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.202229		54.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.310083		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.412641		65.00
66.00	06600 PHYSICAL THERAPY	0.288841		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.052312		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111938		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.083868		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.304742		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.307553		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.373049		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet C
Part I
Date/Time Prepared:
11/23/2015 3:53 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2,751,103	2,751,103	0	2,751,103	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000 SUBPROVIDER - I/PF	2,785,846	2,785,846	0	2,785,846	40.00
41.00	04100 SUBPROVIDER - I/RF	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	771,493	771,493	0	771,493	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	24,515	24,515	0	24,515	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,199,091	1,199,091	0	1,199,091	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000 LABORATORY	1,406,889	1,406,889	0	1,406,889	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	259,171	259,171	0	259,171	65.00
66.00	06600 PHYSICAL THERAPY	739,810	739,810	0	739,810	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	23,109	23,109	0	23,109	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	155,627	155,627	0	155,627	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10,753	10,753	0	10,753	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	991,018	991,018	0	991,018	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0	0	90.00
91.00	09100 EMERGENCY	3,043,916	3,043,916	0	3,043,916	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	372,544	372,544	0	372,544	92.00
200.00	Subtotal (see instructions)	14,534,885	14,534,885	0	14,534,885	200.00
201.00	Less Observation Beds	372,544	372,544	0	372,544	201.00
202.00	Total (see instructions)	14,162,341	14,162,341	0	14,162,341	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet C
Part I
Date/Time Prepared:
11/23/2015 3:53 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,434,196		2,434,196		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
40.00	04000	SUBPROVIDER - IPF	5,020,931		5,020,931		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	165,757	1,163,621	1,329,378	0.580341	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	19,215	206,973	226,188	0.108383	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,296,063	4,633,312	5,929,375	0.202229	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	988,067	3,549,067	4,537,134	0.310083	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	317,436	310,642	628,078	0.412641	65.00
66.00	06600	PHYSICAL THERAPY	1,122,065	1,439,242	2,561,307	0.288841	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	169,516	272,237	441,753	0.052312	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	505,968	884,325	1,390,293	0.111938	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	128,213	128,213	0.083868	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,954,421	1,297,569	3,251,990	0.304742	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	2,838,325	7,058,872	9,897,197	0.307553	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	271,326	271,326	1.373049	92.00
200.00		Subtotal (see instructions)	16,831,960	21,215,399	38,047,359		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	16,831,960	21,215,399	38,047,359		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/23/2015 3:53 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
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				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 151325

Period: From 07/01/2014 To 06/30/2015

Worksheet C Part II Date/Time Prepared: 11/23/2015 3:53 pm

Cost Center Description		Title XIX Hospital Cost				
		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	771,493	119,278	652,215	0	0
51.00	05100 RECOVERY ROOM	0	0	0	0	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300 ANESTHESIOLOGY	24,515	11,372	13,143	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,199,091	79,202	1,119,889	0	0
56.00	05600 RADIOISOTOPE	0	0	0	0	0
57.00	05700 CT SCAN	0	0	0	0	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000 LABORATORY	1,406,889	64,812	1,342,077	0	0
60.01	06001 BLOOD LABORATORY	0	0	0	0	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500 RESPIRATORY THERAPY	259,171	14,443	244,728	0	0
66.00	06600 PHYSICAL THERAPY	739,810	57,723	682,087	0	0
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY	23,109	3,200	19,909	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	155,627	12,452	143,175	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10,753	432	10,321	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	991,018	28,160	962,858	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0	0	0
91.00	09100 EMERGENCY	3,043,916	89,944	2,953,972	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	372,544	49,028	323,516	0	0
200.00	Subtotal (sum of lines 50 thru 199)	8,997,936	530,046	8,467,890	0	0
201.00	Less Observation Beds	372,544	49,028	323,516	0	0
202.00	Total (line 200 minus line 201)	8,625,392	481,018	8,144,374	0	0

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part II Date/Time Prepared: 11/23/2015 3:53 pm
		Title XIX		Hospital Cost

Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part 1, 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	771,493	1,329,378	0.580341	50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	24,515	226,188	0.108383	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,199,091	5,929,375	0.202229	54.00
56.00 05600 RADIOISOTOPE	0	0	0.000000	56.00
57.00 05700 CT SCAN	0	0	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	59.00
60.00 06000 LABORATORY	1,406,889	4,537,134	0.310083	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	259,171	628,078	0.412641	65.00
66.00 06600 PHYSICAL THERAPY	739,810	2,561,307	0.288841	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	23,109	441,753	0.052312	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	155,627	1,390,293	0.111938	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10,753	128,213	0.083868	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	991,018	3,251,990	0.304742	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0.000000	90.00
91.00 09100 EMERGENCY	3,043,916	9,897,197	0.307553	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	372,544	271,326	1.373049	92.00
200.00 Subtotal (sum of lines 50 thru 199)	8,997,936	30,592,232		200.00
201.00 Less Observation Beds	372,544	0		201.00
202.00 Total (line 200 minus line 201)	8,625,392	30,592,232		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part II Date/Time Prepared: 11/23/2015 3:53 pm
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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	119,278	1,329,378	0.089725	12,904	1,158	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	11,372	226,188	0.050277	2,196	110	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	79,202	5,929,375	0.013358	59,806	799	54.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	64,812	4,537,134	0.014285	126,628	1,809	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	14,443	628,078	0.022996	122,797	2,824	65.00
66.00	06600 PHYSICAL THERAPY	57,723	2,561,307	0.022537	39,181	883	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	3,200	441,753	0.007244	29,471	213	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12,452	1,390,293	0.008956	121,359	1,087	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	432	128,213	0.003369	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	28,160	3,251,990	0.008659	360,691	3,123	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	89,944	9,897,197	0.009088	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	49,028	271,326	0.180698	0	0	92.00
200.00	Total (lines 50-199)	530,046	30,592,232		875,033	12,006	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet D
Part IV
Date/Time Prepared:
11/23/2015 3:53 pm

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/23/2015 3:53 pm
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Cost Center Description			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
			6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,329,378	0.000000	0.000000	12,904	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	226,188	0.000000	0.000000	2,196	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,929,375	0.000000	0.000000	59,806	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	4,537,134	0.000000	0.000000	126,628	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	628,078	0.000000	0.000000	122,797	65.00
66.00	06600	PHYSICAL THERAPY	0	2,561,307	0.000000	0.000000	39,181	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	441,753	0.000000	0.000000	29,471	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,390,293	0.000000	0.000000	121,359	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	128,213	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,251,990	0.000000	0.000000	360,691	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	9,897,197	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	271,326	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	30,592,232			875,033	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/23/2015 3:53 pm
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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)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
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						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/23/2015 3:53 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.580341	0	494,126	0	0
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.108383	0	88,206	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.202229	0	1,335,817	0	0
56.00 05600 RADIOISOTOPE	0.000000	0	0	0	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.310083	0	1,119,798	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.412641	0	310,642	0	0
66.00 06600 PHYSICAL THERAPY	0.288841	0	269,547	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.052312	0	272,237	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111938	0	328,762	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.083868	0	71,616	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.304742	0	521,718	514	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.307553	0	1,755,503	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.373049	0	271,326	0	0
200.00 Subtotal (see instructions)		0	6,839,298	514	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (Line 200 +/- Line 201)		0	6,839,298	514	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/23/2015 3:53 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	286,762	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	9,560	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	270,141	0		54.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	347,230	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	128,184	0		65.00
66.00 06600 PHYSICAL THERAPY	77,856	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	14,241	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	36,801	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6,006	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	158,989	157		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	539,910	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	372,544	0		92.00
200.00 Subtotal (see instructions)	2,248,224	157		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (Line 200 +/- Line 201)	2,248,224	157		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part II Date/Time Prepared: 11/23/2015 3:53 pm
		Component CCN: 15M325	Title XVIII	Subprovider - IPF

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	119,278	1,329,378	0.089725	4,792	430
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0
53.00	05300	ANESTHESIOLOGY	11,372	226,188	0.050277	549	28
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,202	5,929,375	0.013358	120,502	1,610
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0
57.00	05700	CT SCAN	0	0	0.000000	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0
60.00	06000	LABORATORY	64,812	4,537,134	0.014285	294,610	4,209
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	14,443	628,078	0.022996	29,325	674
66.00	06600	PHYSICAL THERAPY	57,723	2,561,307	0.022537	57,820	1,303
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0
69.00	06900	ELECTROCARDIOLOGY	3,200	441,753	0.007244	67,756	491
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,452	1,390,293	0.008956	61,194	548
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	432	128,213	0.003369	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	28,160	3,251,990	0.008659	468,745	4,059
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	0
91.00	09100	EMERGENCY	89,944	9,897,197	0.009088	1,813	16
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	271,326	0.000000	0	0
200.00		Total (lines 50-199)	481,018	30,592,232		1,107,106	13,368

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/23/2015 3:53 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/23/2015 3:53 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	1,329,378	0.000000	0.000000	4,792	50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00 05300 ANESTHESIOLOGY	0	226,188	0.000000	0.000000	549	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	5,929,375	0.000000	0.000000	120,502	54.00
56.00 05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00 05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	4,537,134	0.000000	0.000000	294,610	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	628,078	0.000000	0.000000	29,325	65.00
66.00 06600 PHYSICAL THERAPY	0	2,561,307	0.000000	0.000000	57,820	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	441,753	0.000000	0.000000	67,756	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,390,293	0.000000	0.000000	61,194	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	128,213	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3,251,990	0.000000	0.000000	468,745	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	9,897,197	0.000000	0.000000	1,813	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	271,326	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	30,592,232			1,107,106	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/23/2015 3:53 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
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					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151325 Component CCN: 15Z325	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/23/2015 3:53 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.580341	0	0	0	0
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.108383	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.202229	0	0	0	0
56.00 05600 RADIOISOTOPE	0.000000	0	0	0	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.310083	0	0	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.412641	0	0	0	0
66.00 06600 PHYSICAL THERAPY	0.288841	0	0	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.052312	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111938	0	0	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.083868	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.304742	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.307553	0	0	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.373049	0	0	0	0
200.00 Subtotal (see instructions)		0	0	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (Line 200 +/- Line 201)		0	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151325 Component CCN: 15Z325	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/23/2015 3:53 pm
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
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				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (Line 200 +/- Line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part I Date/Time Prepared: 11/23/2015 3:53 pm
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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	178,709	90,498	88,211	1,294	68.17	30.00	
31.00	INTENSIVE CARE UNIT	0	0	0	0	0.00	31.00	
40.00	SUBPROVIDER - IPF	127,367	0	127,367	3,577	35.61	40.00	
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00	
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00	
200.00	Total (lines 30-199)	306,076		215,578	4,871		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	42	2,863					30.00
31.00	INTENSIVE CARE UNIT	0	0					31.00
40.00	SUBPROVIDER - IPF	0	0					40.00
41.00	SUBPROVIDER - IRF	0	0					41.00
42.00	SUBPROVIDER	0	0					42.00
200.00	Total (lines 30-199)	42	2,863					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part II Date/Time Prepared: 11/23/2015 3:53 pm
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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	119,278	1,329,378	0.089725	148,061	13,285	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	11,372	226,188	0.050277	16,470	828	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	79,202	5,929,375	0.013358	1,071,484	14,313	54.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	64,812	4,537,134	0.014285	453,368	6,476	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	14,443	628,078	0.022996	55,166	1,269	65.00
66.00	06600 PHYSICAL THERAPY	57,723	2,561,307	0.022537	91,698	2,067	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	3,200	441,753	0.007244	60,256	436	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12,452	1,390,293	0.008956	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	432	128,213	0.003369	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	28,160	3,251,990	0.008659	193,661	1,677	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	89,944	9,897,197	0.009088	2,836,512	25,778	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	49,028	271,326	0.180698	0	0	92.00
200.00	Total (lines 50-199)	530,046	30,592,232		4,926,676	66,129	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151325		Period: From 07/01/2014 To 06/30/2015		Worksheet D Part III Date/Time Prepared: 11/23/2015 3:53 pm	
Cost Center Description			Title XIX		Hospital		Cost	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,294	0.00	42	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,577	0.00	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	0	42.00
200.00		Total (lines 30-199)	4,871		42	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XIX				Hospital		Total Cost (sum of col 1 through col. 4)
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet D
Part IV
Date/Time Prepared:
11/23/2015 3:53 pm

Cost Center Description			Title XIX			Hospital		Cost
			Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
			6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,329,378	0.000000	0.000000	148,061	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	226,188	0.000000	0.000000	16,470	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,929,375	0.000000	0.000000	1,071,484	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	4,537,134	0.000000	0.000000	453,368	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	628,078	0.000000	0.000000	55,166	65.00
66.00	06600	PHYSICAL THERAPY	0	2,561,307	0.000000	0.000000	91,698	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	441,753	0.000000	0.000000	60,256	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,390,293	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	128,213	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,251,990	0.000000	0.000000	193,661	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	9,897,197	0.000000	0.000000	2,836,512	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	271,326	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	30,592,232			4,926,676	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet D
Part IV
Date/Time Prepared:
11/23/2015 3:53 pm

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)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
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						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 11/23/2015 3:53 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,616	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,294	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)		939	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		594	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)		594	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		567	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)		567	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		652	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)		594	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)		594	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,751,103	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)		73,222	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)		73,222	25.00
26.00	Total swing-bed cost (see instructions)		1,393,155	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,357,948	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)		1,357,948	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)		1,049.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		684,222	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)		684,222	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/23/2015 3:53 pm		
Cost Center Description			Title XVIII		Hospital		
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
			1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT			0	0	0.00	0
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)						246,120
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						930,342
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
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0
52.00	Total Program excludable cost (sum of lines 50 and 51)						0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0
55.00	Target amount per discharge						0.00
56.00	Target amount (line 54 x line 55)						0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0
58.00	Bonus payment (see instructions)						0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00
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
62.00	Relief payment (see instructions)						0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0
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)						623,355
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						623,355
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						1,246,710
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0
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)						355
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,049.42
89.00	Observation bed cost (line 87 x line 88) (see instructions)						372,544

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/23/2015 3:53 pm	
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	178,709	1,357,948	0.131602	372,544	49,028	90.00
91.00	Nursing School cost	0	1,357,948	0.000000	372,544	0	91.00
92.00	Allied health cost	0	1,357,948	0.000000	372,544	0	92.00
93.00	All other Medical Education	0	1,357,948	0.000000	372,544	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1
		Component CCN: 15M325		Date/Time Prepared: 11/23/2015 3:53 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,577	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,577	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)		3,577	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,940	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,785,846	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,785,846	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)		2,785,846	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)		778.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,289,731	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)		2,289,731	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1		
		Component CCN: 15M325				Date/Time Prepared: 11/23/2015 3:53 pm		
		Title XVIII		Subprovider - IPF		PPS		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
	1.00	2.00	3.00	4.00	5.00			
42.00	NURSERY (title V & XIX only)						42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	0	0	0.00	0	0	43.00		
44.00	INTENSIVE CARE UNIT						44.00	
45.00	CORONARY CARE UNIT						45.00	
46.00	BURN INTENSIVE CARE UNIT						46.00	
47.00	SURGICAL INTENSIVE CARE UNIT						47.00	
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)						301,164	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						2,590,895	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)						13,368	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						13,368	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						2,577,527	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)						0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325 Component CCN: 15M325		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/23/2015 3:53 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	2,785,846	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,785,846	0.000000	0	0	91.00
92.00	Allied health cost	0	2,785,846	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,785,846	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/23/2015 3:53 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,616 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,294 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)			939 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			594 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)			594 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			567 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)			567 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			42 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			129.14 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			129.14 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,751,103 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)			73,222 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)			73,222 25.00
26.00	Total swing-bed cost (see instructions)			1,393,155 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,357,948 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)			1,357,948 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)			1,049.42 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			44,076 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)			44,076 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1	
Date/Time Prepared: 11/23/2015 3:53 pm		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		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)					1,428,775		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,472,851		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)						355	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,049.42	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						372,544	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/23/2015 3:53 pm	
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	178,709	1,357,948	0.131602	372,544	49,028	90.00
91.00	Nursing School cost	0	1,357,948	0.000000	372,544	0	91.00
92.00	Allied health cost	0	1,357,948	0.000000	372,544	0	92.00
93.00	All other Medical Education	0	1,357,948	0.000000	372,544	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Prepared: 11/23/2015 3:53 pm	
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		501,633		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.580341	12,904	7,489	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.108383	2,196	238	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.202229	59,806	12,095	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.310083	126,628	39,265	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.412641	122,797	50,671	65.00
66.00	06600 PHYSICAL THERAPY	0.288841	39,181	11,317	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.052312	29,471	1,542	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111938	121,359	13,585	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.083868	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.304742	360,691	109,918	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.307553	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.373049	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		875,033	246,120	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)		875,033		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Prepared: 11/23/2015 3:53 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		4,132,158	40.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
42.00	04200 SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.580341	4,792	2,781 50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.108383	549	60 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.202229	120,502	24,369 54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0 56.00
57.00	05700 CT SCAN	0.000000	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000 LABORATORY	0.310083	294,610	91,354 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0 60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0 63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.412641	29,325	12,101 65.00
66.00	06600 PHYSICAL THERAPY	0.288841	57,820	16,701 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.052312	67,756	3,544 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111938	61,194	6,850 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.083868	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.304742	468,745	142,846 73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000	0	0 90.00
91.00	09100 EMERGENCY	0.307553	1,813	558 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.373049	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,107,106	301,164 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		1,107,106	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3	
		Component CCN: 15Z325		Date/Time Prepared: 11/23/2015 3:53 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.580341	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.108383	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202229	44,271	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.310083	113,461	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.412641	105,847	65.00
66.00	06600	PHYSICAL THERAPY	0.288841	553,611	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.052312	12,033	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111938	114,242	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.083868	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304742	340,693	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.307553	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.373049	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,284,158	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)		1,284,158	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Prepared: 11/23/2015 3:53 pm	
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		86,160	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.580341	148,061	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.108383	16,470	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202229	1,071,484	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.310083	453,368	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.412641	55,166	65.00
66.00	06600	PHYSICAL THERAPY	0.288841	91,698	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.052312	60,256	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111938	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.083868	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304742	193,661	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.307553	2,836,512	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.373049	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,926,676	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)		4,926,676	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/23/2015 3:53 pm
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			2,248,381 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)			2,248,381 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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			2,270,865 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)			18,923 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,152,532 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			1,099,410 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,099,410 30.00
31.00	Primary payer payments			1,182 31.00
32.00	Subtotal (line 30 minus line 31)			1,098,228 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)			292,358 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			222,192 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			281,047 36.00
37.00	Subtotal (see instructions)			1,320,420 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00				0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			1,320,420 40.00
40.01	Sequestration adjustment (see instructions)			26,408 40.01
41.00	Interim payments			1,526,707 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-232,695 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
11/23/2015 3:53 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		722,035		1,526,707	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	01/07/2015	78,700		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)		78,700		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)		800,735		1,526,707	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		11,010		232,695	6.02	
7.00	Total Medicare program liability (see instructions)		789,725		1,294,012	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: 151325
Component CCN: 15M325

Period:
From 07/01/2014
To 06/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
11/23/2015 3:53 pm
PPS

Title XVIII

Subprovider -
IPF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,141,227		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)		2,141,227		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,141,227		0	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: 151325
Component CCN: 15Z325

Period:
From 07/01/2014
To 06/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
11/23/2015 3:53 pm

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,503,535		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	01/07/2015	110,800		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)		110,800		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,614,335		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		44,112		0	6.02
7.00	Total Medicare program liability (see instructions)		1,570,223		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 FOR HIT

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet E-1 Part II Date/Time Prepared: 11/23/2015 3:53 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			236 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			652 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			61 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			939 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			38,047,359 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			793,901 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			104,259 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			101,705 8.00
9.00	Sequestration adjustment amount (see instructions)			2,034 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			99,671 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			99,671 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet E-2
Component CCN: 15Z325		Date/Time Prepared: 11/23/2015 3:53 pm
Title XVIII	Swing Beds - SNF	Cost
	Part A	Part B
	1.00	2.00

COMPUTATION OF NET COST OF COVERED SERVICES		Part A	Part B	
		1.00	2.00	
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,259,177	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)	368,608	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	1,188	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,627,785	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,627,785	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,627,785	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	25,517	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,602,268	0	15.00
16.00		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	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)	1,602,268	0	19.00
19.01	Sequestration adjustment (see instructions)	32,045	0	19.01
20.00	Interim payments	1,614,335	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)	-44,112	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: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part V Date/Time Prepared: 11/23/2015 3:53 pm
		Title VIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		930,342	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)		930,342	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		939,645	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)		939,645	19.00
20.00	Deductibles (exclude professional component)		139,916	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		799,729	22.00
23.00	Coinsurance		912	23.00
24.00	Subtotal (line 22 minus line 23)		798,817	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		9,243	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		7,025	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		8,032	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		805,842	28.00
29.00			0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (see instructions)		805,842	30.00
30.01	Sequestration adjustment (see instructions)		16,117	30.01
31.00	Interim payments		800,735	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)		-11,010	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: 151325 Component CCN: 15M325	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part II Date/Time Prepared: 11/23/2015 3:53 pm
		Title XVII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,342,429 1.00
2.00	Net IPF PPS Outlier Payments			20,219 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			9.800000 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2,362,648 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,362,648 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,362,648 18.00
19.00	Deductibles			154,376 19.00
20.00	Subtotal (line 18 minus line 19)			2,208,272 20.00
21.00	Coinsurance			23,346 21.00
22.00	Subtotal (line 20 minus line 21)			2,184,926 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,184,926 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00				0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			2,184,926 31.00
31.01	Sequestration adjustment (see instructions)			43,699 31.01
32.00	Interim payments			2,141,227 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			0 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			20,219 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151325	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 11/23/2015 3:53 pm	
		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		1,472,851		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)		1,472,851	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)		1,472,851	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		86,160		8.00
9.00	Ancillary service charges		4,926,676	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)		5,012,836	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)		5,012,836	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		3,539,985	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)		1,472,851	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)		1,472,851	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)		1,472,851	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1,472,851	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		1,472,851	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)		1,472,851	0	40.00
41.00	Interim payments		1,472,851	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0		43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet G

Date/Time Prepared:
11/23/2015 3:53 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,016,596	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,832,971	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,366,373	0	0	0	6.00
7.00	Inventory	167,686	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	110,865	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)	3,761,745	0	0	0	11.00
FIXED ASSETS						
12.00	Land	445,242	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	11,648,899	0	0	0	15.00
16.00	Accumulated depreciation	-8,517,229	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	8,025,071	0	0	0	19.00
20.00	Accumulated depreciation	-6,764,017	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	4,837,966	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	851,983	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	2,827,276	499,849	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,679,259	499,849	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	12,278,970	499,849	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	399,085	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	-564	0	0	0	39.00
40.00	Notes and loans payable (short term)	93,472	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,753,943	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,245,936	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	4,016,933	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,016,933	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,262,869	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	2,016,101				52.00
53.00	Specific purpose fund		499,849			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)	2,016,101	499,849	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	12,278,970	499,849	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet G-1

Date/Time Prepared:
11/23/2015 3:53 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		652,611		499,849		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		36,039				2.00
3.00	Total (sum of line 1 and line 2)		688,650		499,849		3.00
4.00	TRANSFER TO/FROM AFFILIATES	2,187,751		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		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)		2,187,751		0		10.00
11.00	Subtotal (line 3 plus line 10)		2,876,401		499,849		11.00
12.00	DEFERRED PENSION COST ADJUSTMENT	860,300		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		860,300		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		2,016,101		499,849		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	TRANSFER TO/FROM AFFILIATES		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	DEFERRED PENSION COST ADJUSTMENT		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/23/2015 3:53 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,697,224		2,697,224	1.00
2.00	SUBPROVIDER - IPF	5,042,865		5,042,865	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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)	7,740,089		7,740,089	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	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)	7,740,089		7,740,089	17.00
18.00	Ancillary services	5,194,660	14,806,846	20,001,506	18.00
19.00	Outpatient services	113,047	10,294,478	10,407,525	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NRCC	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,047,796	25,101,324	38,149,120	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,725,059		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00		0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		14,725,059		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151325

Period:
From 07/01/2014
To 06/30/2015

Worksheet G-3

Date/Time Prepared:
11/23/2015 3:53 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	38,149,120	1.00
2.00	Less contractual allowances and discounts on patients' accounts	23,716,389	2.00
3.00	Net patient revenues (line 1 minus line 2)	14,432,731	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,725,059	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-292,328	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-7,122	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	37,139	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	1,845	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	-402	24.00
24.01	EXERCISE REVENUE	18,269	24.01
24.02	HOUSEKEEPING REVENUE	8,040	24.02
24.03	OTHER MAINTENANCE REVENUE	600	24.03
24.04	GRANT REVENUE	1,552	24.04
24.05	INCOME - GENESIS	4,942	24.05
24.06	OTHER OPERATING REVENUE	52,662	24.06
24.07	STATE PROGRAM REVENUE	30,253	24.07
24.08	HEALTHCARE PLAN FEE REVENUE	5,508	24.08
24.09	GOV'T CLINICAL INCENTIVE REVENUE	45,213	24.09
24.10	OTHER LAB REVENUE	110	24.10
24.11	PHYSICIAN CLINIC	48,569	24.11
24.12	JAIL	81,189	24.12
25.00	Total other income (sum of lines 6-24)	328,367	25.00
26.00	Total (line 5 plus line 25)	36,039	26.00
27.00	OTHER EXPENSES (SPECIFY)	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)	36,039	29.00