

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: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/24/2015 8:51 am
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<b>PART I - COST REPORT STATUS</b>			
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: 11/24/2015	Time: 8:51 am
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 VINCENT SALEM ( 151314 ) 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	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	47,600	-155,178	0	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
5.00 Swing bed - SNF	0	42,158	0	0	0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	89,758	-155,178	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/24/2015 8:15 am
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1.00	2.00	3.00	4.00	1.00	2.00
Hospital and Hospital Health Care Complex Address:					
1.00 Street: 911 N. SHELBY STREET		PO Box:		1.00	
2.00 City: SALEM		State: IN		2.00	
		Zip Code: 47167		County: WASHINGTON	

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ST VINCENT SALEM	151314	31140	1	12/01/2002	N	0	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST VINCENT SALEM	152314	31140		12/01/2002	N	0	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)					2		21.00	

Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					N	N	22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N	22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N	22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2		N	23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00	0	0	0	0	0	0	24.00
25.00	0	0	0	0	0	0	25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/24/2015 8:15 am			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
<b>Prospective Payment System (PPS)-Capital</b>							
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	
<b>Teaching Hospitals</b>							
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	Unweighted FTEs Nonprovi der Si te	Unweighted 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
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
				1.00		
<b>Long Term Care Hospital PPS</b>						
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
<b>TEFRA Providers</b>						
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.			N		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	
<b>Title V and XIX Services</b>						
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.				Y	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		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N			96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		97.00
<b>Rural Providers</b>							
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	
<b>Miscellaneous Cost Reporting Information</b>							
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:	21,883	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
<b>Transplant Center Information</b>							
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: 151314		Period: From 07/01/2014 To 06/30/2015		Worksheet S-2 Part I Date/Time Prepared: 11/24/2015 8:15 am	
		1.00		2.00			
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		15H046		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: ST VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08001			
142.00	Street: 10330 N. MERIDIAN STREET	PO Box:					
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46290			
		1.00		2.00			
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00			
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00			
		1.00		2.00			
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	
		1.00		2.00		3.00	
		Title V		Title XIX			
		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		155.00	
156.00	Subprovider - IPF	N		N		156.00	
157.00	Subprovider - IRF	N		N		157.00	
158.00	SUBPROVIDER	N		N		158.00	
159.00	SNF	N		N		159.00	
160.00	HOME HEALTH AGENCY	N		N		160.00	
161.00	CMHC	N		N		161.00	
		1.00		2.00			
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	
		0		1.00		2.00	
		Zip Code		CBSA		FTE/Campus	
		3.00		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
		1.00		2.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	N		167.00			
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0			
168.01	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			
		Beginni ng		Endi ng			
		1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/24/2015 8:15 am
			1.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N 171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/24/2015 8:15 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		Y	10/08/2015	Y
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
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
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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/24/2015 8:15 am
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	1.00 N	2.00	3.00 N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
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
<b>Interest Expense</b>					
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
<b>Purchased Services</b>					
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
<b>Provider-Based Physicians</b>					
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.			Y	35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
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
<b>Cost Report Preparer Contact Information</b>					
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		
<b>PS&amp;R Data</b>				
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	
<b>Cost Report Preparer Contact Information</b>				
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.	MANAGER, REIMBURSEMENT		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: 151314

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/24/2015 8:15 am

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	11,424.00	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	11,424.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	11,424.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151314

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/24/2015 8:15 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	323	31	476			1.00
2.00 HMO and other (see instructions)	45	10				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	292	0	292			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	41			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	615	31	809			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)	615	31	809	0.00	108.59	14.00
15.00 CAH visits	10,025	1,742	29,325			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	108.59	27.00
28.00 Observation Bed Days		0	457			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			6			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: 151314

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/24/2015 8:15 am

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	104	10	202	1.00
2.00 HMO and other (see instructions)			18	6		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	104	10	202	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					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: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet S-10 Date/Time Prepared: 11/24/2015 8:15 am
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.317988	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,315,288	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		9,617,543	6.00	
7.00	Medicaid cost (line 1 times line 6)		3,058,263	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)		1,742,975	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)		1,742,975	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,444,045	270,744	2,714,789	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	777,177	86,093	863,270	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	777,177	86,093	863,270	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,476,921	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		850,704	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		626,217	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		199,129	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,062,399	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,805,374	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 151314		Period: From 07/01/2014 To 06/30/2015		Worksheet A	
Date/Time Prepared: 11/24/2015 8:15 am								
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		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100		248,732	248,732	0	248,732		1.00
2.00	00200		0	0	0	0		2.00
3.00	00300		0	0	0	0		3.00
4.00	00400	323,441	1,929,315	2,252,756	0	2,252,756		4.00
5.00	00500	1,265,130	1,824,892	3,090,022	0	3,090,022		5.00
7.00	00700	52,077	1,471,993	1,524,070	0	1,524,070		7.00
8.00	00800	0	0	0	0	0		8.00
9.00	00900	0	375,682	375,682	0	375,682		9.00
10.00	01000	0	481,858	481,858	-411,450	70,408		10.00
11.00	01100	0	0	0	411,450	411,450		11.00
13.00	01300	0	8,974	8,974	0	8,974		13.00
14.00	01400	111,261	22,130	133,391	0	133,391		14.00
15.00	01500	163,024	150,237	313,261	0	313,261		15.00
16.00	01600	258,073	14,061	272,134	0	272,134		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	744,246	88,223	832,469	-13,058	819,411		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	522,896	393,978	916,874	-105,681	811,193		50.00
54.00	05400	593,957	473,034	1,066,991	0	1,066,991		54.00
58.00	05800	58,802	147,065	205,867	0	205,867		58.00
60.00	06000	0	1,169,370	1,169,370	0	1,169,370		60.00
61.00	06100	0	0	0	0	0		61.00
65.00	06500	247,393	15,509	262,902	0	262,902		65.00
66.00	06600	350,062	15,450	365,512	-3,214	362,298		66.00
67.00	06700	58,249	278	58,527	133	58,660		67.00
68.00	06800	0	0	0	0	0		68.00
69.00	06900	112,752	4,154	116,906	0	116,906		69.00
70.00	07000	0	0	0	0	0		70.00
71.00	07100	0	7,950	7,950	149,102	157,052		71.00
72.00	07200	0	82,406	82,406	0	82,406		72.00
73.00	07300	0	156,690	156,690	0	156,690		73.00
74.00	07400	0	0	0	0	0		74.00
75.00	07500	0	0	0	0	0		75.00
75.01	03950	143,547	66,860	210,407	0	210,407		75.01
75.03	07501	0	408,838	408,838	0	408,838		75.03
76.97	07697	76,121	9,554	85,675	0	85,675		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	0	0	0	0	0		88.00
89.00	08900	0	0	0	0	0		89.00
90.00	09000	0	0	0	0	0		90.00
91.00	09100	674,049	979,598	1,653,647	-27,282	1,626,365		91.00
92.00	09200	0	0	0	0	0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		5,755,080	10,546,831	16,301,911	0	16,301,911		118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	0	0	0	0	0		190.00
191.00	19100	0	0	0	0	0		191.00
192.00	19200	123,865	2,375	126,240	0	126,240		192.00
193.00	19300	0	0	0	0	0		193.00
193.01	19301	57,876	6,786	64,662	0	64,662		193.01
193.02	19302	7,786	715	8,501	0	8,501		193.02
200.00		5,944,607	10,556,707	16,501,314	0	16,501,314		200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151314

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

Worksheet A  
Date/Time Prepared:  
11/24/2015 8:15 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100			1.00
		0	248,732	
2.00	00200		0	2.00
		0	0	
3.00	00300		0	3.00
		0	0	
4.00	00400	-176,422	2,076,334	4.00
5.00	00500	574,652	3,664,674	5.00
7.00	00700	-33,857	1,490,213	7.00
8.00	00800	0	0	8.00
9.00	00900	0	375,682	9.00
10.00	01000	0	70,408	10.00
11.00	01100	-63,848	347,602	11.00
13.00	01300	0	8,974	13.00
14.00	01400	0	133,391	14.00
15.00	01500	0	313,261	15.00
16.00	01600	-6,169	265,965	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	-54,909	764,502	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	0	811,193	50.00
54.00	05400	-152,349	914,642	54.00
58.00	05800	0	205,867	58.00
60.00	06000	0	1,169,370	60.00
61.00	06100	0	0	61.00
65.00	06500	0	262,902	65.00
66.00	06600	-225	362,073	66.00
67.00	06700	0	58,660	67.00
68.00	06800	0	0	68.00
69.00	06900	-21,221	95,685	69.00
70.00	07000	0	0	70.00
71.00	07100	0	157,052	71.00
72.00	07200	0	82,406	72.00
73.00	07300	0	156,690	73.00
74.00	07400	0	0	74.00
75.00	07500	0	0	75.00
75.01	03950	-52,712	157,695	75.01
75.03	07501	0	408,838	75.03
76.97	07697	0	85,675	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	0	0	88.00
89.00	08900	0	0	89.00
90.00	09000	0	0	90.00
91.00	09100	-150,000	1,476,365	91.00
92.00	09200	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00		-137,060	16,164,851	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	0	0	190.00
191.00	19100	0	0	191.00
192.00	19200	0	126,240	192.00
193.00	19300	0	0	193.00
193.01	19301	63,170	127,832	193.01
193.02	19302	0	8,501	193.02
200.00		-73,890	16,427,424	200.00

RECLASSIFICATIONS

Provider CCN: 151314

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

Worksheet A-6

Date/Time Prepared:  
11/24/2015 8:15 am

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
<b>A - CAFETERIA</b>					
1.00	CAFETERIA	11.00	0	411,450	1.00
	TOTALS		0	411,450	
<b>B - BILLABLE MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	149,102	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	149,102	
<b>C - PT / OT</b>					
1.00	PHYSICAL THERAPY	66.00	1,765	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0	1,898	2.00
	TOTALS		1,765	1,898	
500.00	Grand Total: Increases		1,765	562,450	500.00

RECLASSIFICATIONS

Provider CCN: 151314

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

Worksheet A-6

Date/Time Prepared:  
11/24/2015 8:15 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
<b>A - CAFETERIA</b>						
1.00	DIETARY	10.00	0	411,450	0	1.00
	TOTALS		0	411,450		
<b>B - BILLABLE MEDICAL SUPPLIES</b>						
1.00	ADULTS & PEDIATRICS	30.00	0	13,058	0	1.00
2.00	OPERATING ROOM	50.00	0	105,681	0	2.00
3.00	PHYSICAL THERAPY	66.00	0	3,081	0	3.00
4.00	EMERGENCY	91.00	0	27,282	0	4.00
	TOTALS		0	149,102		
<b>C - PT / OT</b>						
1.00	OCCUPATIONAL THERAPY	67.00	1,765	0	0	1.00
2.00	PHYSICAL THERAPY	66.00	0	1,898	0	2.00
	TOTALS		1,765	1,898		
500.00	Grand Total: Decreases		1,765	562,450		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151314

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/24/2015 8:15 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	180,000	0	180,000	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	516,397	485,714	0	485,714	0	3.00
4.00	Building Improvements	856,968	0	0	0	0	4.00
5.00	Fixed Equipment	503,809	34,612	0	34,612	0	5.00
6.00	Movable Equipment	436,042	885,248	0	885,248	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	2,313,216	1,585,574	0	1,585,574	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	2,313,216	1,585,574	0	1,585,574	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	180,000	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	1,002,111	0				3.00
4.00	Building Improvements	856,968	0				4.00
5.00	Fixed Equipment	538,421	0				5.00
6.00	Movable Equipment	1,321,290	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	3,898,790	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	3,898,790	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151314

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/24/2015 8:15 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	211,875	0	36,857	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	211,875	0	36,857	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	248,732				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	248,732				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151314

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
11/24/2015 8:15 am

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	3,898,790	0	3,898,790	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	3,898,790	0	3,898,790	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 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	211,875	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	211,875	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	36,857	0	0	248,732	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	36,857	0	0	248,732	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151314

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

Worksheet A-8

Date/Time Prepared:  
11/24/2015 8:15 am

Line #	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 #			
				3.00	4.00			
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)			0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00	Television and radio service (chapter 21)			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	-408,785				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	796,058				0	12.00
13.00	Laundry and linen service			0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-63,848	CAFETERIA		11.00	0	14.00
15.00	Rental of quarters to employee and others			0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00	Sale of drugs to other than patients			0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-19,905	MEDICAL RECORDS & LIBRARY		16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00	Vending machines			0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	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			0		0.00	0	32.00
33.00	OTHER REVENUE - RADIOLOGY	B	-73	RADIOLOGY - DIAGNOSTIC		54.00	0	33.00
33.01	OTHER REVENUE - ADMINISTRATION	B	-5,356	ADMINISTRATIVE & GENERAL		5.00	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		
33.02 ASSOCIATION DUES LOBBYING EXPENSE	A	-656	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 PROVIDER TAX	A	-193,454	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 CABLE TV	A	-3,471	OPERATION OF PLANT	7.00	0	33.04
33.05 BIOTERRORISM GRANT	B	-21,517	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06 MEDICAL RECORDS FOR SPN	A	13,736	MEDICAL RECORDS & LIBRARY	16.00	0	33.06
33.07 PROFESSIONAL COMP BENEFITS	A	-5,710	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08 BUILDING RENTAL INCOME	B	-21,221	ELECTROCARDIOLOGY	69.00	0	33.08
33.09 BUILDING RENTAL INCOME	B	-1,112	SLEEP DISORDER	75.01	0	33.09
33.10 BUILDING RENTAL INCOME	B	-225	PHYSICAL THERAPY	66.00	0	33.10
33.11 BUILDING RENTAL INCOME	B	-44,845	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12 PAYROLL INCENTIVE	A	-93,506	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13		0		0.00	0	33.13
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-73,890				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: 151314

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

Worksheet A-8-1

Date/Time Prepared: 11/24/2015 8:15 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT HOME OFFICE	82,602	82,602	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL HOME OFFICE	1,942,086	1,101,606	2.00
3.00	193.01	MARKETING/ PUBLIC RELATIONS HOME OFFICE	63,170	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT SVH CHARGEBACKS	132,277	132,277	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL SVH CHARGEBACKS	587,810	587,810	4.01
4.02	13.00	NURSING ADMINISTRATION SVH CHARGEBACKS	1,926	1,926	4.02
4.03	14.00	CENTRAL SERVICES & SUPPLY SVH CHARGEBACKS	123,539	123,539	4.03
4.04	16.00	MEDICAL RECORDS & LIBRARY SVH CHARGEBACKS	61,319	61,319	4.04
4.05	54.00	RADIOLOGY - DIAGNOSTIC SVH CHARGEBACKS	11,999	11,999	4.05
4.06	4.00	EMPLOYEE BENEFITS DEPARTMENT HOME OFFICE SELF INSURANCE	938,516	1,037,046	4.06
4.07	7.00	OPERATION OF PLANT ASCENSION - TRI MEDX	761,065	791,451	4.07
4.08	4.00	EMPLOYEE BENEFITS DEPARTMENT ASCENSION - PENSION	243,098	221,774	4.08
4.09	0.00		0	0	4.09
4.10	0.00		0	0	4.10
4.11	0.00		0	0	4.11
4.12	0.00		0	0	4.12
4.13	0.00		0	0	4.13
5.00	0	0	4,949,407	4,153,349	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.

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

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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	G	ASCENSION HEALT	100.00	ASCENSION HEALT	100.00	6.00
7.00	G	ST VINCENT HEAL	100.00	ST VINCENT HEAL	100.00	7.00
8.00	G	CATHOLIC HEALTH	100.00	CATHOLIC HEALTH	100.00	8.00
9.00	A	TRI MEDX	0.00	TRI MEDX	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 151314

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

Worksheet A-8-1

Date/Time Prepared:  
11/24/2015 8:15 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>			
1.00	0	0	1.00
2.00	840,480	0	2.00
3.00	63,170	0	3.00
4.00	0	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
4.03	0	0	4.03
4.04	0	0	4.04
4.05	0	0	4.05
4.06	-98,530	0	4.06
4.07	-30,386	0	4.07
4.08	21,324	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
5.00	796,058		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 requested 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	HOME OFFICE		7.00
8.00	HOME OFFICE		8.00
9.00	TECHNOLOGY MGMT		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151314

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

Worksheet A-8-2

Date/Time Prepared:  
11/24/2015 8:15 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	856,151	150,000	706,151	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	54,909	54,909	0	0	0	2.00
3.00	54.00	RADIOLOGY - DIAGNOSTIC	172,510	152,276	20,234	0	0	3.00
4.00	75.01	SLEEP DISORDER	51,600	51,600	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			1,135,170	408,785	726,385	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	3.00
4.00	75.01	SLEEP DISORDER	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	150,000		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	54,909		2.00
3.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	152,276		3.00
4.00	75.01	SLEEP DISORDER	0	0	0	51,600		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	408,785		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151314

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/24/2015 8:15 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	248,732	248,732			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,076,334	2,893	0	2,079,227	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,664,674	27,205	0	467,963	5.00
7.00 00700	OPERATION OF PLANT	1,490,213	40,418	0	19,263	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	375,682	7,588	0	0	9.00
10.00 01000	DIETARY	70,408	23,880	0	0	10.00
11.00 01100	CAFETERIA	347,602	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	8,974	943	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	133,391	0	0	41,155	14.00
15.00 01500	PHARMACY	313,261	2,433	0	60,301	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	265,965	11,575	0	95,459	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	764,502	27,492	0	275,291	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	811,193	26,464	0	193,415	50.00
54.00 05400	RADIOLOGY - DIAGNOSTIC	914,642	13,009	0	219,700	54.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	205,867	3,044	0	21,750	58.00
60.00 06000	LABORATORY	1,169,370	4,635	0	0	60.00
61.00 06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	61.00
65.00 06500	RESPIRATORY THERAPY	262,902	2,681	0	91,509	65.00
66.00 06600	PHYSICAL THERAPY	362,073	5,807	0	130,138	66.00
67.00 06700	OCCUPATIONAL THERAPY	58,660	931	0	20,893	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	95,685	6,897	0	41,706	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	157,052	0	0	0	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	82,406	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	156,690	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01 03950	SLEEP DISORDER	157,695	6,991	0	53,097	75.01
75.03 07501	ADULT MENTAL HEALTH	408,838	5,749	0	0	75.03
76.97 07697	CARDIAC REHABILITATION	85,675	3,242	0	28,157	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	1,476,365	11,087	0	249,325	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	16,164,851	234,964	0	2,009,122	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	126,240	12,160	0	45,817	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.01 19301	MARKETING/ PUBLIC RELATIONS	127,832	0	0	21,408	193.01
193.02 19302	NEW HORIZON OP	8,501	1,608	0	2,880	193.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	16,427,424	248,732	0	2,079,227	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151314

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/24/2015 8:15 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,159,842				5.00
7.00	00700	OPERATION OF PLANT	525,557	2,075,451			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0		8.00
9.00	00900	HOUSEKEEPING	129,964	88,364	0	601,598	9.00
10.00	01000	DIETARY	31,972	278,096	0	0	10.00
11.00	01100	CAFETERIA	117,869	0	0	1,597	11.00
13.00	01300	NURSING ADMINISTRATION	3,363	10,986	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	59,187	0	0	8,626	14.00
15.00	01500	PHARMACY	127,497	28,334	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	126,481	134,802	0	9,585	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	361,908	320,164	0	153,674	404,356
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	349,628	308,196	0	154,314	0
54.00	05400	RADIOLOGY - DIAGNOSTIC	389,058	151,505	0	25,879	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	78,215	35,452	0	0	0
60.00	06000	LABORATORY	398,096	53,977	0	29,074	0
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY					61.00
65.00	06500	RESPIRATORY THERAPY	121,087	31,220	0	0	0
66.00	06600	PHYSICAL THERAPY	168,874	67,625	0	21,406	0
67.00	06700	OCCUPATIONAL THERAPY	27,291	10,846	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	48,927	80,321	0	18,530	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	53,255	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	27,943	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	53,132	0	0	9,585	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	03950	SLEEP DISORDER	73,848	81,414	0	29,712	0
75.03	07501	ADULT MENTAL HEALTH	140,583	66,953	0	22,045	0
76.97	07697	CARDIAC REHABILITATION	39,699	37,750	0	15,335	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	588,931	129,113	0	81,789	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,042,365	1,915,118	0	581,151	404,356
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	5,751	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	62,467	141,612	0	13,738	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	MARKETING/ PUBLIC RELATIONS	50,606	0	0	0	0
193.02	19302	NEW HORIZON OP	4,404	18,721	0	958	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	4,159,842	2,075,451	0	601,598	404,356

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151314

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/24/2015 8:15 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	467,068					11.00
13.00	01300		24,266				13.00
14.00	01400	17,129	0	259,488			14.00
15.00	01500	11,876	0	0	543,702		15.00
16.00	01600	40,200	0	0	0	684,067	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	80,077	3,347	10,456	0	40,402	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	50,863	3,975	84,621	0	132,275	50.00
54.00	05400	62,253	3,556	0	0	99,621	54.00
58.00	05800	5,422	0	0	0	0	58.00
60.00	06000	0	1,674	0	0	0	60.00
61.00	06100						61.00
65.00	06500	28,234	837	0	0	0	65.00
66.00	06600	34,620	2,301	2,467	0	0	66.00
67.00	06700	4,455	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	14,264	418	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	91,886	0	0	71.00
72.00	07200	0	0	48,213	0	0	72.00
73.00	07300	0	2,301	0	543,702	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	03950	18,952	0	0	0	0	75.01
75.03	07501	0	0	0	0	0	75.03
76.97	07697	9,325	1,464	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	68,331	2,929	21,845	0	319,342	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		446,001	22,802	259,488	543,702	591,640	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	14,086	1,464	0	0	92,427	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	6,000	0	0	0	0	193.01
193.02	19302	981	0	0	0	0	193.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		467,068	24,266	259,488	543,702	684,067	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151314

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/24/2015 8:15 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
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
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	2,441,669	0	2,441,669	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	2,114,944	0	2,114,944	50.00
54.00	05400	1,879,223	0	1,879,223	54.00
58.00	05800	349,750	0	349,750	58.00
60.00	06000	1,656,826	0	1,656,826	60.00
61.00	06100	0	0	0	61.00
65.00	06500	538,470	0	538,470	65.00
66.00	06600	795,311	0	795,311	66.00
67.00	06700	123,076	0	123,076	67.00
68.00	06800	0	0	0	68.00
69.00	06900	306,748	0	306,748	69.00
70.00	07000	0	0	0	70.00
71.00	07100	302,193	0	302,193	71.00
72.00	07200	158,562	0	158,562	72.00
73.00	07300	765,410	0	765,410	73.00
74.00	07400	0	0	0	74.00
75.00	07500	0	0	0	75.00
75.01	03950	421,709	0	421,709	75.01
75.03	07501	644,168	0	644,168	75.03
76.97	07697	220,647	0	220,647	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	0	0	0	90.00
91.00	09100	2,949,057	0	2,949,057	91.00
92.00	09200	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		15,667,763	0	15,667,763	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	5,751	0	5,751	190.00
191.00	19100	0	0	0	191.00
192.00	19200	510,011	0	510,011	192.00
193.00	19300	0	0	0	193.00
193.01	19301	205,846	0	205,846	193.01
193.02	19302	38,053	0	38,053	193.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		16,427,424	0	16,427,424	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151314

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/24/2015 8:15 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
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	297	2,893	0	3,190	3,190 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	504,961	27,205	0	532,166	723 5.00
7.00 00700	OPERATION OF PLANT	257,020	40,418	0	297,438	30 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00 00900	HOUSEKEEPING	0	7,588	0	7,588	0 9.00
10.00 01000	DIETARY	916	23,880	0	24,796	0 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	4,528	943	0	5,471	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,840	0	0	1,840	63 14.00
15.00 01500	PHARMACY	50,546	2,433	0	52,979	92 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,768	11,575	0	15,343	146 16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	16,299	27,492	0	43,791	422 30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	58,536	26,464	0	85,000	296 50.00
54.00 05400	RADIOLOGY - DIAGNOSTIC	116,347	13,009	0	129,356	337 54.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	126,513	3,044	0	129,557	33 58.00
60.00 06000	LABORATORY	1,381	4,635	0	6,016	0 60.00
61.00 06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY				0	0 61.00
65.00 06500	RESPIRATORY THERAPY	4,162	2,681	0	6,843	140 65.00
66.00 06600	PHYSICAL THERAPY	297	5,807	0	6,104	199 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	931	0	931	32 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	1,084	6,897	0	7,981	64 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
75.01 03950	SLEEP DISORDER	4,635	6,991	0	11,626	81 75.01
75.03 07501	ADULT MENTAL HEALTH	0	5,749	0	5,749	0 75.03
76.97 07697	CARDIAC REHABILITATION	7,179	3,242	0	10,421	43 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	8,664	11,087	0	19,751	382 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0 92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,168,973	234,964	0	1,403,937	3,083 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0 190.00
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	595	12,160	0	12,755	70 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.01 19301	MARKETING/ PUBLIC RELATIONS	1,840	0	0	1,840	33 193.01
193.02 19302	NEW HORIZON OP	0	1,608	0	1,608	4 193.02
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	1,171,408	248,732	0	1,420,140	3,190 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151314		Period: From 07/01/2014 To 06/30/2015		Worksheet B Part II Date/Time Prepared: 11/24/2015 8:15 am		
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	532,889				5.00	
7.00	00700	OPERATION OF PLANT	67,326	364,794			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0		8.00	
9.00	00900	HOUSEKEEPING	16,649	15,531	0	39,768	9.00	
10.00	01000	DIETARY	4,096	48,880	0	0	10.00	
11.00	01100	CAFETERIA	15,099	0	0	106	11.00	
13.00	01300	NURSING ADMINISTRATION	431	1,931	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	7,582	0	0	570	14.00	
15.00	01500	PHARMACY	16,333	4,980	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	16,203	23,694	0	634	16.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	46,362	56,274	0	10,158	77,772	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	44,789	54,170	0	10,200	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	49,840	26,630	0	1,711	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,020	6,231	0	0	0	58.00
60.00	06000	LABORATORY	50,998	9,487	0	1,922	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	15,512	5,487	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	21,633	11,886	0	1,415	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,496	1,906	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,268	14,118	0	1,225	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,822	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,580	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,806	0	0	634	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	9,460	14,310	0	1,964	0	75.01
75.03	07501	ADULT MENTAL HEALTH	18,009	11,768	0	1,457	0	75.03
76.97	07697	CARDIAC REHABILITATION	5,086	6,635	0	1,014	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	75,440	22,694	0	5,407	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	517,840	336,612	0	38,417	77,772	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	380	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,002	24,891	0	908	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	6,483	0	0	0	0	193.01
193.02	19302	NEW HORIZON OP	564	3,291	0	63	0	193.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	532,889	364,794	0	39,768	77,772	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151314		Period: From 07/01/2014 To 06/30/2015		Worksheet B Part II Date/Time Prepared: 11/24/2015 8:15 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	15,205					11.00
13.00	01300		7,833				13.00
14.00	01400	558	0	10,613			14.00
15.00	01500	387	0	0	74,771		15.00
16.00	01600	1,309	0	0	0	57,329	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,605	1,080	428	0	3,386	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,656	1,283	3,461	0	11,085	50.00
54.00	05400	2,027	1,148	0	0	8,349	54.00
58.00	05800	177	0	0	0	0	58.00
60.00	06000	0	540	0	0	0	60.00
61.00	06100						61.00
65.00	06500	919	270	0	0	0	65.00
66.00	06600	1,127	743	101	0	0	66.00
67.00	06700	145	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	464	135	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	3,758	0	0	71.00
72.00	07200	0	0	1,972	0	0	72.00
73.00	07300	0	743	0	74,771	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	03950	617	0	0	0	0	75.01
75.03	07501	0	0	0	0	0	75.03
76.97	07697	304	473	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	2,224	945	893	0	26,763	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		14,519	7,360	10,613	74,771	49,583	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	459	473	0	0	7,746	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	195	0	0	0	0	193.01
193.02	19302	32	0	0	0	0	193.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		15,205	7,833	10,613	74,771	57,329	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet B Part II Date/Time Prepared: 11/24/2015 8:15 am
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
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
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	242,278	0	242,278	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	211,940	0	211,940	50.00
54.00	05400	219,398	0	219,398	54.00
58.00	05800	146,018	0	146,018	58.00
60.00	06000	68,963	0	68,963	60.00
61.00	06100				61.00
65.00	06500	29,171	0	29,171	65.00
66.00	06600	43,208	0	43,208	66.00
67.00	06700	6,510	0	6,510	67.00
68.00	06800	0	0	0	68.00
69.00	06900	30,255	0	30,255	69.00
70.00	07000	0	0	0	70.00
71.00	07100	10,580	0	10,580	71.00
72.00	07200	5,552	0	5,552	72.00
73.00	07300	82,954	0	82,954	73.00
74.00	07400	0	0	0	74.00
75.00	07500	0	0	0	75.00
75.01	03950	38,058	0	38,058	75.01
75.03	07501	36,983	0	36,983	75.03
76.97	07697	23,976	0	23,976	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	0	0	0	90.00
91.00	09100	154,499	0	154,499	91.00
92.00	09200	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		1,350,343	0	1,350,343	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	380	0	380	190.00
191.00	19100	0	0	0	191.00
192.00	19200	55,304	0	55,304	192.00
193.00	19300	0	0	0	193.00
193.01	19301	8,551	0	8,551	193.01
193.02	19302	5,562	0	5,562	193.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		1,420,140	0	1,420,140	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151314

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

Worksheet B-1  
Date/Time Prepared:  
11/24/2015 8:15 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	103,359				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		0			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,202	0	5,621,166		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	11,305	0	1,265,130	-4,159,842	5.00
7.00 00700	OPERATION OF PLANT	16,796	0	52,077	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	3,153	0	0	0	9.00
10.00 01000	DIETARY	9,923	0	0	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	392	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	111,261	0	14.00
15.00 01500	PHARMACY	1,011	0	163,024	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,810	0	258,073	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	11,424	0	744,246	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	10,997	0	522,896	0	50.00
54.00 05400	RADIOLOGY - DIAGNOSTIC	5,406	0	593,957	0	54.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,265	0	58,802	0	58.00
60.00 06000	LABORATORY	1,926	0	0	0	60.00
61.00 06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY				0	61.00
65.00 06500	RESPIRATORY THERAPY	1,114	0	247,393	0	65.00
66.00 06600	PHYSICAL THERAPY	2,413	0	351,827	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	387	0	56,484	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	2,866	0	112,752	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01 03950	SLEEP DISORDER	2,905	0	143,547	0	75.01
75.03 07501	ADULT MENTAL HEALTH	2,389	0	0	0	75.03
76.97 07697	CARDIAC REHABILITATION	1,347	0	76,121	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	4,607	0	674,049	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	97,638	0	5,431,639	-4,159,842	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	5,053	0	123,865	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.01 19301	MARKETING/ PUBLIC RELATIONS	0	0	57,876	0	193.01
193.02 19302	NEW HORIZON OP	668	0	7,786	0	193.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	248,732	0	2,079,227	4,159,842	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.406486	0.000000	0.369892	0.339092	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			3,190	532,889	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000567	0.043439	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151314

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

Worksheet B-1  
Date/Time Prepared:  
11/24/2015 8:15 am

Cost Center Description		OPERATION OF PLANT (SQ. FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	74,056				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0			8.00
9.00	00900	HOUSEKEEPING	3,153	0	1,883		9.00
10.00	01000	DIETARY	9,923	0	0	890	10.00
11.00	01100	CAFETERIA	0	0	5	0	11.00
13.00	01300	NURSING ADMINISTRATION	392	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	27	0	14.00
15.00	01500	PHARMACY	1,011	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,810	0	30	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	11,424	0	481	890	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	10,997	0	483	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	5,406	0	81	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,265	0	0	0	58.00
60.00	06000	LABORATORY	1,926	0	91	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY					61.00
65.00	06500	RESPIRATORY THERAPY	1,114	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,413	0	67	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	387	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,866	0	58	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	30	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	2,905	0	93	0	75.01
75.03	07501	ADULT MENTAL HEALTH	2,389	0	69	0	75.03
76.97	07697	CARDIAC REHABILITATION	1,347	0	48	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,607	0	256	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	68,335	0	1,819	890	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	18	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,053	0	43	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	0	0	0	0	193.01
193.02	19302	NEW HORIZON OP	668	0	3	0	193.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,075,451	0	601,598	404,356	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.025427	0.000000	319.489113	454.332584	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	364,794	0	39,768	77,772	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.925921	0.000000	21.119490	87.384270	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151314

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
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
13.00	01300	116				13.00
14.00	01400	0	443,522			14.00
15.00	01500	0	0	100		15.00
16.00	01600	0	0	0	1,236	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	16	17,872	0	73	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	19	144,636	0	239	50.00
54.00	05400	17	0	0	180	54.00
58.00	05800	0	0	0	0	58.00
60.00	06000	8	0	0	0	60.00
61.00	06100					61.00
65.00	06500	4	0	0	0	65.00
66.00	06600	11	4,217	0	0	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
69.00	06900	2	0	0	0	69.00
70.00	07000	0	0	0	0	70.00
71.00	07100	0	157,053	0	0	71.00
72.00	07200	0	82,406	0	0	72.00
73.00	07300	11	0	100	0	73.00
74.00	07400	0	0	0	0	74.00
75.00	07500	0	0	0	0	75.00
75.01	03950	0	0	0	0	75.01
75.03	07501	0	0	0	0	75.03
76.97	07697	7	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	0	0	0	0	88.00
89.00	08900	0	0	0	0	89.00
90.00	09000	0	0	0	0	90.00
91.00	09100	14	37,338	0	577	91.00
92.00	09200					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		109	443,522	100	1,069	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
191.00	19100	0	0	0	0	191.00
192.00	19200	7	0	0	167	192.00
193.00	19300	0	0	0	0	193.00
193.01	19301	0	0	0	0	193.01
193.02	19302	0	0	0	0	193.02
200.00						200.00
201.00						201.00
202.00		24,266	259,488	543,702	684,067	202.00
203.00		209.189655	0.585062	5,437.020000	553.452265	203.00
204.00		7,833	10,613	74,771	57,329	204.00
205.00		67.525862	0.023929	747.710000	46.382686	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C  
Part I  
Date/Time Prepared:  
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		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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	2,441,669		2,441,669	0	0 30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	2,114,944		2,114,944	0	0 50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	1,879,223		1,879,223	0	0 54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	349,750		349,750	0	0 58.00
60.00	06000 LABORATORY	1,656,826		1,656,826	0	0 60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0		0	0	0 61.00
65.00	06500 RESPIRATORY THERAPY	538,470	0	538,470	0	0 65.00
66.00	06600 PHYSICAL THERAPY	795,311	0	795,311	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	123,076	0	123,076	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	306,748		306,748	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	302,193		302,193	0	0 71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	158,562		158,562	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	765,410		765,410	0	0 73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0 74.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0 75.00
75.01	03950 SLEEP DISORDER	421,709		421,709	0	0 75.01
75.03	07501 ADULT MENTAL HEALTH	644,168		644,168	0	0 75.03
76.97	07697 CARDIAC REHABILITATION	220,647		220,647	0	0 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0 89.00
90.00	09000 CLINIC	0		0	0	0 90.00
91.00	09100 EMERGENCY	2,949,057		2,949,057	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	908,918		908,918	0	0 92.00
200.00	Subtotal (see instructions)	16,576,681	0	16,576,681	0	0 200.00
201.00	Less Observation Beds	908,918		908,918	0	0 201.00
202.00	Total (see instructions)	15,667,763	0	15,667,763	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C  
Part I  
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		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	10.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,328,532		1,328,532			30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	326,630	6,670,464	6,997,094	0.302260	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	118,781	11,123,966	11,242,747	0.167150	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,802	1,504,688	1,511,490	0.231394	0.000000	58.00
60.00	06000	LABORATORY	301,949	7,073,293	7,375,242	0.224647	0.000000	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	0.000000	61.00
65.00	06500	RESPIRATORY THERAPY	96,915	625,161	722,076	0.745725	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	203,954	2,232,885	2,436,839	0.326370	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	47,915	343,306	391,221	0.314595	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	31,663	1,471,839	1,503,502	0.204022	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	230,958	1,481,042	1,712,000	0.176515	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	93,987	301,827	395,814	0.400597	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	352,568	2,385,966	2,738,534	0.279496	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	03950	SLEEP DISORDER	0	988,347	988,347	0.426681	0.000000	75.01
75.03	07501	ADULT MENTAL HEALTH	0	1,197,374	1,197,374	0.537984	0.000000	75.03
76.97	07697	CARDIAC REHABILITATION	0	142,555	142,555	1.547803	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	63,517	7,797,120	7,860,637	0.375168	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	11,433	716,096	727,529	1.249322	0.000000	92.00
200.00		Subtotal (see instructions)	3,215,604	46,055,929	49,271,533			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,215,604	46,055,929	49,271,533			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/24/2015 8:15 am
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.000000	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000 LABORATORY	0.000000	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	61.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0.000000	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	75.00
75.01	03950 SLEEP DISORDER	0.000000	75.01
75.03	07501 ADULT MENTAL HEALTH	0.000000	75.03
76.97	07697 CARDIAC REHABILITATION	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		89.00
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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C  
Part I  
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		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		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	2,441,669		2,441,669	0	2,441,669	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,114,944		2,114,944	0	2,114,944	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	1,879,223		1,879,223	0	1,879,223	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	349,750		349,750	0	349,750	58.00
60.00	06000 LABORATORY	1,656,826		1,656,826	0	1,656,826	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0		0	0	0	61.00
65.00	06500 RESPIRATORY THERAPY	538,470	0	538,470	0	538,470	65.00
66.00	06600 PHYSICAL THERAPY	795,311	0	795,311	0	795,311	66.00
67.00	06700 OCCUPATIONAL THERAPY	123,076	0	123,076	0	123,076	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	306,748		306,748	0	306,748	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	302,193		302,193	0	302,193	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	158,562		158,562	0	158,562	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	765,410		765,410	0	765,410	73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	03950 SLEEP DISORDER	421,709		421,709	0	421,709	75.01
75.03	07501 ADULT MENTAL HEALTH	644,168		644,168	0	644,168	75.03
76.97	07697 CARDIAC REHABILITATION	220,647		220,647	0	220,647	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	2,949,057		2,949,057	0	2,949,057	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	908,918		908,918	0	908,918	92.00
200.00	Subtotal (see instructions)	16,576,681	0	16,576,681	0	16,576,681	200.00
201.00	Less Observation Beds	908,918		908,918	0	908,918	201.00
202.00	Total (see instructions)	15,667,763	0	15,667,763	0	15,667,763	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/24/2015 8:15 am

		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	10.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,328,532		1,328,532			30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	326,630	6,670,464	6,997,094	0.302260	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	118,781	11,123,966	11,242,747	0.167150	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,802	1,504,688	1,511,490	0.231394	0.000000	58.00
60.00	06000	LABORATORY	301,949	7,073,293	7,375,242	0.224647	0.000000	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	0.000000	61.00
65.00	06500	RESPIRATORY THERAPY	96,915	625,161	722,076	0.745725	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	203,954	2,232,885	2,436,839	0.326370	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	47,915	343,306	391,221	0.314595	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	31,663	1,471,839	1,503,502	0.204022	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	230,958	1,481,042	1,712,000	0.176515	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	93,987	301,827	395,814	0.400597	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	352,568	2,385,966	2,738,534	0.279496	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	03950	SLEEP DISORDER	0	988,347	988,347	0.426681	0.000000	75.01
75.03	07501	ADULT MENTAL HEALTH	0	1,197,374	1,197,374	0.537984	0.000000	75.03
76.97	07697	CARDIAC REHABILITATION	0	142,555	142,555	1.547803	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	63,517	7,797,120	7,860,637	0.375168	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	11,433	716,096	727,529	1.249322	0.000000	92.00
200.00		Subtotal (see instructions)	3,215,604	46,055,929	49,271,533			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,215,604	46,055,929	49,271,533			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/24/2015 8:15 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.000000			54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000			61.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000			75.00
75.01	03950 SLEEP DISORDER	0.000000			75.01
75.03	07501 ADULT MENTAL HEALTH	0.000000			75.03
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part II Date/Time Prepared: 11/24/2015 8:15 am
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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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	211,940	6,997,094	0.030290	146,722	4,444	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	219,398	11,242,747	0.019515	46,935	916	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	146,018	1,511,490	0.096605	3,401	329	58.00
60.00	06000 LABORATORY	68,963	7,375,242	0.009351	141,849	1,326	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500 RESPIRATORY THERAPY	29,171	722,076	0.040399	34,389	1,389	65.00
66.00	06600 PHYSICAL THERAPY	43,208	2,436,839	0.017731	34,160	606	66.00
67.00	06700 OCCUPATIONAL THERAPY	6,510	391,221	0.016640	5,107	85	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	30,255	1,503,502	0.020123	24,630	496	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10,580	1,712,000	0.006180	102,190	632	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	5,552	395,814	0.014027	51,106	717	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	82,954	2,738,534	0.030291	167,351	5,069	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	03950 SLEEP DISORDER	38,058	988,347	0.038507	0	0	75.01
75.03	07501 ADULT MENTAL HEALTH	36,983	1,197,374	0.030887	0	0	75.03
76.97	07697 CARDIAC REHABILITATION	23,976	142,555	0.168188	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	154,499	7,860,637	0.019655	5,590	110	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	118,672	727,529	0.163117	9,259	1,510	92.00
200.00	Total (lines 50-199)	1,226,737	47,943,001		772,689	17,629	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/24/2015 8:15 am

Cost Center Description		Title XVIII				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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/24/2015 8:15 am
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Cost Center Description	Title XVIII			Hospital		Inpatient Program Charges		
	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)	Cost			
	6.00	7.00	8.00	9.00	10.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	6,997,094	0.000000	0.000000	146,722	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	11,242,747	0.000000	0.000000	46,935	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,511,490	0.000000	0.000000	3,401	58.00
60.00	06000	LABORATORY	0	7,375,242	0.000000	0.000000	141,849	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	0	722,076	0.000000	0.000000	34,389	65.00
66.00	06600	PHYSICAL THERAPY	0	2,436,839	0.000000	0.000000	34,160	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	391,221	0.000000	0.000000	5,107	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,503,502	0.000000	0.000000	24,630	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,712,000	0.000000	0.000000	102,190	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	395,814	0.000000	0.000000	51,106	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,738,534	0.000000	0.000000	167,351	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	03950	SLEEP DISORDER	0	988,347	0.000000	0.000000	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	1,197,374	0.000000	0.000000	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	142,555	0.000000	0.000000	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	7,860,637	0.000000	0.000000	5,590	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	727,529	0.000000	0.000000	9,259	92.00
200.00		Total (lines 50-199)	0	47,943,001			772,689	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/24/2015 8:15 am

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		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000 LABORATORY	0	0	0		60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0		61.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	03950 SLEEP DISORDER	0	0	0		75.01
75.03	07501 ADULT MENTAL HEALTH	0	0	0		75.03
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
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: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/24/2015 8:15 am
	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
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.302260	0	2,067,386	0	0
54.00 05400 RADIOLOGY - DIAGNOSTIC	0.167150	0	3,249,060	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.231394	0	450,900	0	0
60.00 06000 LABORATORY	0.224647	0	2,447,302	0	0
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.745725	0	55,872	0	0
66.00 06600 PHYSICAL THERAPY	0.326370	0	613,084	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.314595	0	33,029	0	0
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.204022	0	812,743	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.176515	0	535,631	0	0
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.400597	0	106,020	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.279496	0	1,093,538	1,942	0
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0
75.01 03950 SLEEP DISORDER	0.426681	0	309,412	0	0
75.03 07501 ADULT MENTAL HEALTH	0.537984	0	969,644	0	0
76.97 07697 CARDIAC REHABILITATION	1.547803	0	47,196	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0
90.00 09000 CLINIC	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.375168	0	1,757,320	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.249322	0	375,501	0	0
200.00 Subtotal (see instructions)		0	14,923,638	1,942	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 +/- line 201)		0	14,923,638	1,942	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/24/2015 8:15 am
	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		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	624,888	0		50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	543,080	0		54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	104,336	0		58.00
60.00 06000 LABORATORY	549,779	0		60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		61.00
65.00 06500 RESPIRATORY THERAPY	41,665	0		65.00
66.00 06600 PHYSICAL THERAPY	200,092	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	10,391	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	165,817	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	94,547	0		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	42,471	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	305,639	543		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
75.01 03950 SLEEP DISORDER	132,020	0		75.01
75.03 07501 ADULT MENTAL HEALTH	521,653	0		75.03
76.97 07697 CARDIAC REHABILITATION	73,050	0		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	659,290	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	469,122	0		92.00
200.00 Subtotal (see instructions)	4,537,840	543		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	4,537,840	543		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151314 Component CCN: 15Z314	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/24/2015 8:15 am
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
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.302260	0	0	0	0
54.00 05400 RADIOLOGY - DIAGNOSTIC	0.167150	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.231394	0	0	0	0
60.00 06000 LABORATORY	0.224647	0	0	0	0
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000		0	0	0
65.00 06500 RESPIRATORY THERAPY	0.745725	0	0	0	0
66.00 06600 PHYSICAL THERAPY	0.326370	0	0	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.314595	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.204022	0	0	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.176515	0	0	0	0
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.400597	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.279496	0	0	0	0
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0
75.01 03950 SLEEP DISORDER	0.426681	0	0	0	0
75.03 07501 ADULT MENTAL HEALTH	0.537984	0	0	0	0
76.97 07697 CARDIAC REHABILITATION	1.547803	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
90.00 09000 CLINIC	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.375168	0	0	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.249322	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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151314 Component CCN: 15Z314	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/24/2015 8:15 am
	Title XVIII	Swing Beds - SNF	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		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0		54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00 06000 LABORATORY	0	0		60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		61.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
75.01 03950 SLEEP DISORDER	0	0		75.01
75.03 07501 ADULT MENTAL HEALTH	0	0		75.03
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
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: 151314		Period: From 07/01/2014 To 06/30/2015		Worksheet D Part I Date/Time Prepared: 11/24/2015 8:15 am	
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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	242,278	57,751	184,527	933	197.78	30.00
200.00	Total (Lines 30-199)	242,278		184,527	933		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	31	6,131				
200.00	Total (Lines 30-199)	31	6,131				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part II Date/Time Prepared: 11/24/2015 8:15 am
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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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	211,940	6,997,094	0.030290	72,486	2,196	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	219,398	11,242,747	0.019515	4,779	93	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	146,018	1,511,490	0.096605	0	0	58.00
60.00	06000 LABORATORY	68,963	7,375,242	0.009351	28,036	262	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500 RESPIRATORY THERAPY	29,171	722,076	0.040399	7,290	295	65.00
66.00	06600 PHYSICAL THERAPY	43,208	2,436,839	0.017731	3,847	68	66.00
67.00	06700 OCCUPATIONAL THERAPY	6,510	391,221	0.016640	872	15	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	30,255	1,503,502	0.020123	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10,580	1,712,000	0.006180	55,237	341	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	5,552	395,814	0.014027	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	82,954	2,738,534	0.030291	19,038	577	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	03950 SLEEP DISORDER	38,058	988,347	0.038507	0	0	75.01
75.03	07501 ADULT MENTAL HEALTH	36,983	1,197,374	0.030887	0	0	75.03
76.97	07697 CARDIAC REHABILITATION	23,976	142,555	0.168188	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	154,499	7,860,637	0.019655	15,032	295	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	118,672	727,529	0.163117	0	0	92.00
200.00	Total (lines 50-199)	1,226,737	47,943,001		206,617	4,142	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151314		Period: From 07/01/2014 To 06/30/2015		Worksheet D Part III Date/Time Prepared: 11/24/2015 8:15 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital	Cost	
			1.00	2.00	3.00	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	933	0.00	31	0	0	30.00
200.00		Total (lines 30-199)	933		31	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/24/2015 8:15 am
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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			
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	61.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
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: 151314

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/24/2015 8:15 am

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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	6,997,094	0.000000	0.000000	72,486	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	11,242,747	0.000000	0.000000	4,779	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,511,490	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	7,375,242	0.000000	0.000000	28,036	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0					61.00
65.00	06500	RESPIRATORY THERAPY	0	722,076	0.000000	0.000000	7,290	65.00
66.00	06600	PHYSICAL THERAPY	0	2,436,839	0.000000	0.000000	3,847	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	391,221	0.000000	0.000000	872	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,503,502	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,712,000	0.000000	0.000000	55,237	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	395,814	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,738,534	0.000000	0.000000	19,038	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	03950	SLEEP DISORDER	0	988,347	0.000000	0.000000	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	1,197,374	0.000000	0.000000	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	142,555	0.000000	0.000000	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	7,860,637	0.000000	0.000000	15,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	727,529	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	47,943,001			206,617	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/24/2015 8:15 am

Cost Center Description		Title XIX			Hospital	Cost
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000 LABORATORY	0	0	0		60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0		61.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	03950 SLEEP DISORDER	0	0	0		75.01
75.03	07501 ADULT MENTAL HEALTH	0	0	0		75.03
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
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: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/24/2015 8:15 am
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,266 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			933 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)			476 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			146 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)			146 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			21 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			20 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			323 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			146 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)			146 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
<b>SWING BED ADJUSTMENT</b>				
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)		2,441,669	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		2,712	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		2,583	25.00
26.00	Total swing-bed cost (see instructions)		586,048	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,855,621	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		1,855,621	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,988.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		642,408	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)		642,408	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/24/2015 8:15 am			
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)	
42.00	NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT							43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description								
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						1.00	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						227,221	48.00
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
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	55.00
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	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
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)						290,376	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						290,376	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						580,752	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
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)						457	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,988.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						908,918	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151314		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/24/2015 8:15 am	
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	242,278	1,855,621	0.130564	908,918	118,672	90.00
91.00	Nursing School cost	0	1,855,621	0.000000	908,918	0	91.00
92.00	Allied health cost	0	1,855,621	0.000000	908,918	0	92.00
93.00	All other Medical Education	0	1,855,621	0.000000	908,918	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/24/2015 8:15 am
Cost Center Description		Title XIX	Hospital	Cost
PART I - ALL PROVIDER COMPONENTS				1.00
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,266 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			933 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)			476 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			146 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)			146 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			20 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			21 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			31 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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,441,669	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)		582,014	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,859,655	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		1,859,655	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,993.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		61,789	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)		61,789	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/24/2015 8:15 am	
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)
Title XIX		1.00	2.00	3.00	4.00	5.00
Hospital						
Cost						
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					56,684
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					118,473
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)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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)					457
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,993.20
89.00	Observation bed cost (line 87 x line 88) (see instructions)					910,892

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151314		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/24/2015 8:15 am	
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	242,278	1,859,655	0.130281	910,892	118,672	90.00
91.00	Nursing School cost	0	1,859,655	0.000000	910,892	0	91.00
92.00	Allied health cost	0	1,859,655	0.000000	910,892	0	92.00
93.00	All other Medical Education	0	1,859,655	0.000000	910,892	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Prepared: 11/24/2015 8:15 am	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		324,824		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.302260	146,722	44,348	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.167150	46,935	7,845	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.231394	3,401	787	58.00
60.00	06000 LABORATORY	0.224647	141,849	31,866	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
65.00	06500 RESPIRATORY THERAPY	0.745725	34,389	25,645	65.00
66.00	06600 PHYSICAL THERAPY	0.326370	34,160	11,149	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.314595	5,107	1,607	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.204022	24,630	5,025	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.176515	102,190	18,038	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.400597	51,106	20,473	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.279496	167,351	46,774	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03950 SLEEP DISORDER	0.426681	0	0	75.01
75.03	07501 ADULT MENTAL HEALTH	0.537984	0	0	75.03
76.97	07697 CARDIAC REHABILITATION	1.547803	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.375168	5,590	2,097	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.249322	9,259	11,567	92.00
200.00	Total (sum of lines 50-94 and 96-98)		772,689	227,221	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)		772,689		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3	
		Component CCN: 15Z314		Date/Time Prepared: 11/24/2015 8:15 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS			0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.302260	0	0	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.167150	12,789	2,138	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.231394	0	0	58.00
60.00	06000 LABORATORY	0.224647	42,412	9,528	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
65.00	06500 RESPIRATORY THERAPY	0.745725	10,464	7,803	65.00
66.00	06600 PHYSICAL THERAPY	0.326370	143,598	46,866	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.314595	35,687	11,227	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.204022	7,023	1,433	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.176515	34,838	6,149	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.400597	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.279496	82,935	23,180	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03950 SLEEP DISORDER	0.426681	0	0	75.01
75.03	07501 ADULT MENTAL HEALTH	0.537984	0	0	75.03
76.97	07697 CARDIAC REHABILITATION	1.547803	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.375168	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.249322	2,174	2,716	92.00
200.00	Total (sum of lines 50-94 and 96-98)		371,920	111,040	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)		371,920		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Prepared: 11/24/2015 8:15 am	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		37,272		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.302260	72,486	21,910	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.167150	4,779	799	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.231394	0	0	58.00
60.00	06000 LABORATORY	0.224647	28,036	6,298	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
65.00	06500 RESPIRATORY THERAPY	0.745725	7,290	5,436	65.00
66.00	06600 PHYSICAL THERAPY	0.326370	3,847	1,256	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.314595	872	274	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.204022	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.176515	55,237	9,750	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.400597	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.279496	19,038	5,321	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03950 SLEEP DISORDER	0.426681	0	0	75.01
75.03	07501 ADULT MENTAL HEALTH	0.537984	0	0	75.03
76.97	07697 CARDIAC REHABILITATION	1.547803	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.375168	15,032	5,640	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.249322	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		206,617	56,684	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)		206,617		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/24/2015 8:15 am
		Title XVIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			4,538,383 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)			4,538,383 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
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)			4,583,767 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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			36,463 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,571,600 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)			1,975,704 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)			1,975,704 30.00
31.00	Primary payer payments			1,048 31.00
32.00	Subtotal (line 30 minus line 31)			1,974,656 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			1,098,014 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			834,491 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			933,899 36.00
37.00	Subtotal (see instructions)			2,809,147 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00				0 39.00
39.01				0 39.01
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.98				0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,809,147 40.00
40.01	Sequestration adjustment (see instructions)			56,183 40.01
41.00	Interim payments			2,908,142 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-155,178 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 151314

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/24/2015 8:15 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		677,331		2,908,142	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	01/13/2015	44,300		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	
3.49			0		0	3.49	
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)		44,300		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)		721,631		2,908,142	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		47,600		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		155,178	6.02	
7.00	Total Medicare program liability (see instructions)		769,231		2,752,964	7.00	
		0		Contractor Number	NPR Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151314  
Component CCN: 15Z314

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/24/2015 8:15 am

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		641,343		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
3.49			0		0	3.49
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)		641,343		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		42,158		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		683,501		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet E-2
		Component CCN: 15Z314		Date/Time Prepared: 11/24/2015 8:15 am
		Title XVIII	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		586,560	0
2.00	Inpatient routine services - swing bed-NF (see instructions)			0
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)		112,150	0
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00
5.00	Program days		292	0
6.00	Interns and residents not in approved teaching program (see instructions)			0
7.00	Utilization review - physician compensation - SNF optional method only		0	0
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		698,710	0
9.00	Primary payer payments (see instructions)		0	0
10.00	Subtotal (line 8 minus line 9)		698,710	0
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0
12.00	Subtotal (line 10 minus line 11)		698,710	0
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		1,260	0
14.00	80% of Part B costs (line 12 x 80%)			0
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		697,450	0
16.00			0	0
16.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
16.55	410A RURAL DEMONSTRATION PROJECT		0	0
17.00	Allowable bad debts (see instructions)		0	0
17.01	Adjusted reimbursable bad debts (see instructions)		0	0
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0
19.00	Total (see instructions)		697,450	0
19.01	Sequestration adjustment (see instructions)		13,949	0
20.00	Interim payments		641,343	0
21.00	Tentative settlement (for contractor use only)		0	0
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		42,158	0
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part V Date/Time Prepared: 11/24/2015 8:15 am
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT</b>				
1.00	Inpatient services			869,629 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)			869,629 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			878,325 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)			878,325 19.00
20.00	Deductibles (exclude professional component)			109,608 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			768,717 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			768,717 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			21,333 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			16,213 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			13,768 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			784,930 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)			784,930 30.00
30.01	Sequestration adjustment (see instructions)			15,699 30.01
31.00	Interim payments			721,631 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)			47,600 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: 151314	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 11/24/2015 8:15 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		118,473		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)		118,473	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)		118,473	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		37,272		8.00
9.00	Ancillary service charges		206,617	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)		243,889	0	12.00
<b>CUSTOMARY CHARGES</b>					
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)		243,889	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		125,416	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)		118,473	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
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)		118,473	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
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)		118,473	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)		118,473	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		118,473	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)		118,473	0	40.00
41.00	Interim payments		118,473	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	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: 151314

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

Worksheet G

Date/Time Prepared:  
11/24/2015 8:15 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	7,658,420	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	4,738,623	0	0	0	4.00
5.00	Other receivable	555,141	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,711,184	0	0	0	6.00
7.00	Inventory	417,413	0	0	0	7.00
8.00	Prepaid expenses	177,061	0	0	0	8.00
9.00	Other current assets	295,021	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)	11,130,495	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	180,000	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	1,002,111	0	0	0	15.00
16.00	Accumulated depreciation	-72,203	0	0	0	16.00
17.00	Leasehold improvements	856,968	0	0	0	17.00
18.00	Accumulated depreciation	-856,968	0	0	0	18.00
19.00	Fixed equipment	538,421	0	0	0	19.00
20.00	Accumulated depreciation	-505,540	0	0	0	20.00
21.00	Automobiles and trucks	13,500	0	0	0	21.00
22.00	Accumulated depreciation	-11,531	0	0	0	22.00
23.00	Major movable equipment	1,307,790	0	0	0	23.00
24.00	Accumulated depreciation	-400,192	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,052,356	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	8,658	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,658	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	13,191,509	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	913,717	0	0	0	37.00
38.00	Salaries, wages, and fees payable	626,726	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	77,422	0	0	0	43.00
44.00	Other current liabilities	1,225,973	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,843,838	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,843,838	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	10,347,671	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	10,347,671	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,191,509	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151314

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

Worksheet G-1

Date/Time Prepared:  
11/24/2015 8:15 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		10,788,470		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,380,684			2.00
3.00	Total (sum of line 1 and line 2)		12,169,154		0	3.00
4.00	RELEASED CAPITAL	34,612		0		4.00
5.00	DONATION	44,957		0		5.00
6.00	GRANT REVENUE	18,169		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		97,738		0	10.00
11.00	Subtotal (line 3 plus line 10)		12,266,892		0	11.00
12.00	TRANSFER FROM AFFILIATES	1,809,845		0		12.00
13.00	PENSION ADJUSTMENT	41,740		0		13.00
14.00	RELEASED CAPITAL	34,612		0		14.00
15.00	RELEASED OPERATING	33,020		0		15.00
16.00	ROUNDING	4		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		1,919,221		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,347,671		0	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	RELEASED CAPITAL		0			4.00
5.00	DONATION		0			5.00
6.00	GRANT REVENUE		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	TRANSFER FROM AFFILIATES		0			12.00
13.00	PENSION ADJUSTMENT		0			13.00
14.00	RELEASED CAPITAL		0			14.00
15.00	RELEASED OPERATING		0			15.00
16.00	ROUNDING		0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151314

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/24/2015 8:15 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	2,666,658		2,666,658	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,666,658		2,666,658	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,666,658		2,666,658	17.00
18.00	Ancillary services	1,793,790	36,536,432	38,330,222	18.00
19.00	Outpatient services	63,517	8,211,136	8,274,653	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,523,965	44,747,568	49,271,533	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,501,314		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	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		16,501,314		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151314

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

Worksheet G-3

Date/Time Prepared:  
11/24/2015 8:15 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	49,271,533	1.00
2.00	Less contractual allowances and discounts on patients' accounts	31,523,182	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,748,351	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,501,314	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,247,037	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-73,950	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	63,848	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	19,905	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	85,395	22.00
23.00	Governmental appropriations	0	23.00
24.00		0	24.00
24.01	OTHER	5,429	24.01
24.02	NET ASSETS RELEASED FROM RESTRICTION	33,020	24.02
24.03		0	24.03
24.04		0	24.04
24.05		0	24.05
24.06		0	24.06
25.00	Total other income (sum of lines 6-24)	133,647	25.00
26.00	Total (line 5 plus line 25)	1,380,684	26.00
27.00		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)	1,380,684	29.00