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: 151309	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/24/2015 8:30 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/24/2015 Time: 8:30 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT CLAY HOSPITAL (151309) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-90,235	-298,458	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	6,620	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-83,615	-298,458	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: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/24/2015 8:22 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1206 EAST NATIONAL AVENUE	PO Box:			1.00
2.00	City: BRAZIL	State: IN	Zip Code: 47834	County: CLAY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. VINCENT CLAY HOSPITAL	151309	45460	1	08/08/2001	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT CLAY SWING BEDS	15Z309	45460		08/08/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2014	06/30/2015	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/24/2015 8:22 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/24/2015 8:22 am

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

	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/24/2015 8:22 am

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		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	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	39,282	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151309	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/24/2015 8:22 am

			1.00	2.00	
	All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	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	141.00
142.00	Street: 10330 N. MERIDIAN ST.	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00

			1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00
		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
			1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

						1.00	
	Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00 166.00

			1.00
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		0 168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00 169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151309	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/24/2015 8:22 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/24/2015 8:22 am

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

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

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	10/12/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 11/24/2015 8:22 am

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3519	JILL.HILL@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/24/2015 8:22 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	10/12/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/24/2015 8:22 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	40,896.00	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	40,896.00	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	40,896.00	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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/24/2015 8:22 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,032	77	1,704			1.00
2.00	HMO and other (see instructions)	152	141				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	924	0	924			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	125			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,956	77	2,753			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,956	77	2,753	0.00	99.98	14.00
15.00	CAH visits	12,468	2,033	35,662			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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	99.98	27.00
28.00	Observation Bed Days		0	499			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/24/2015 8:22 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	286	45	488	1.00
2.00	HMO and other (see instructions)			35	21		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	286	45	488	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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-10 | Date/Time Prepared: 11/24/2015 8:22 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.270952	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	540,489	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	10,339,364	6.00
7.00	Medicaid cost (line 1 times line 6)	2,801,471	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,260,982	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,260,982	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,351,467	409,246	3,760,713	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	908,087	110,886	1,018,973	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)	908,087	110,886	1,018,973	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,176,921	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	577,443	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,599,478	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	433,382	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,452,355	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,713,337	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/24/2015 8:22 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		513,022	513,022	-180,419	332,603	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		595,854	595,854	168,796	764,650	2.00
2.01	00201	CAP REL COSTS-MOB		209,475	209,475	-41,810	167,665	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	347,231	1,310,281	1,657,512	0	1,657,512	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,425,070	1,820,743	3,245,813	26,864	3,272,677	5.00
7.00	00700	OPERATION OF PLANT	125,057	773,341	898,398	0	898,398	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	55,766	55,766	0	55,766	8.00
9.00	00900	HOUSEKEEPING	0	361,086	361,086	0	361,086	9.00
10.00	01000	DIETARY	0	366,427	366,427	-171,706	194,721	10.00
11.00	01100	CAFETERIA	0	0	0	171,706	171,706	11.00
13.00	01300	NURSING ADMINISTRATION	212,670	41,326	253,996	0	253,996	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	74,486	74,486	0	74,486	14.00
15.00	01500	PHARMACY	0	903,609	903,609	0	903,609	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	159,341	11,919	171,260	0	171,260	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	960,169	199,360	1,159,529	-7,674	1,151,855	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	432,067	469,115	901,182	-77,070	824,112	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	680,174	553,154	1,233,328	0	1,233,328	54.00
60.00	06000	LABORATORY	15,983	1,131,057	1,147,040	0	1,147,040	60.00
65.00	06500	RESPIRATORY THERAPY	134,061	46,276	180,337	0	180,337	65.00
66.00	06600	PHYSICAL THERAPY	0	663,733	663,733	-34,661	629,072	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67,319	67,319	67.00
68.00	06800	SPEECH PATHOLOGY	0	19,361	19,361	0	19,361	68.00
69.00	06900	ELECTROCARDIOLOGY	108,780	43,602	152,382	-3,158	149,224	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,881	15,881	123,042	138,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	191,430	191,430	0	191,430	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	116	116	0	116	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	806,568	916,690	1,723,258	-32,420	1,690,838	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,407,171	11,287,110	16,694,281	8,809	16,703,090	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	44,131	44,131	-8,809	35,322	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	135	9	144	0	144	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	283	324	607	0	607	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
200.00		TOTAL (SUM OF LINES 118-199)	5,407,589	11,331,574	16,739,163	0	16,739,163	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/24/2015 8:22 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-82,355	250,248		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-151,843	612,807		2.00
2.01	00201	CAP REL COSTS-MOB	0	167,665		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-74,488	1,583,024		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,054,434	4,327,111		5.00
7.00	00700	OPERATION OF PLANT	-14,064	884,334		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	55,766		8.00
9.00	00900	HOUSEKEEPING	0	361,086		9.00
10.00	01000	DIETARY	0	194,721		10.00
11.00	01100	CAFETERIA	-31,638	140,068		11.00
13.00	01300	NURSING ADMINISTRATION	-150	253,846		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	74,486		14.00
15.00	01500	PHARMACY	-1,777	901,832		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,385	163,875		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,682	1,150,173		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-4,409	819,703		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-39,828	1,193,500		54.00
60.00	06000	LABORATORY	0	1,147,040		60.00
65.00	06500	RESPIRATORY THERAPY	-48	180,289		65.00
66.00	06600	PHYSICAL THERAPY	0	629,072		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67,319		67.00
68.00	06800	SPEECH PATHOLOGY	0	19,361		68.00
69.00	06900	ELECTROCARDIOLOGY	-969	148,255		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	138,923		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	191,430		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	116		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-150,787	1,540,051		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	493,011	17,196,101		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	35,322		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0		193.01
193.02	19302	PUBLIC RELATIONS	0	144		193.02
193.03	19303	FOUNDATION	0	0		193.03
193.04	19304	MISSION SERVICES	0	607		193.04
193.05	19305	OTHER NON-REIMBURSABLE	88,267	88,267		193.05
200.00		TOTAL (SUM OF LINES 118-199)	581,278	17,320,441		200.00

RECLASSIFICATIONS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/24/2015 8:22 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - MEDICAL OFFICE BUILDING				
1.00	OCCUPATIONAL THERAPY	67.00	0	2,867	1.00
2.00	PHYSICAL THERAPY	66.00	0	26,355	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	12,589	3.00
4.00	OCCUPATIONAL THERAPY	67.00	0	604	4.00
5.00	PHYSICAL THERAPY	66.00	0	5,552	5.00
6.00	ADMINISTRATIVE & GENERAL	5.00	0	2,652	6.00
	TOTALS		0	50,619	
	B - INTEREST				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,623	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	151,842	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	163,465	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	0	171,706	1.00
	TOTALS		0	171,706	
	D - PROPERTY INSURANCE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	16,954	1.00
	TOTALS		0	16,954	
	E - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	123,042	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	123,042	
	F - OT RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	0	63,848	1.00
	TOTALS		0	63,848	
500.00	Grand Total: Increases		0	589,634	500.00

RECLASSIFICATIONS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/24/2015 8:22 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MEDICAL OFFICE BUILDING						
1.00	CAP REL COSTS-MOB	2.01	0	41,810	9		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	8,809	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		0	50,619			
	B - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	11,623	11		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	151,842	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	163,465			
	C - CAFETERIA						
1.00	DIETARY	10.00	0	171,706	0		1.00
	TOTALS		0	171,706			
	D - PROPERTY INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	16,954	11		1.00
	TOTALS		0	16,954			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	7,674	0		1.00
2.00	OPERATING ROOM	50.00	0	77,070	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	2,720	0		3.00
4.00	ELECTROCARDIOLOGY	69.00	0	3,158	0		4.00
5.00	EMERGENCY	91.00	0	32,420	0		5.00
	TOTALS		0	123,042			
	F - OT RECLASS						
1.00	PHYSICAL THERAPY	66.00	0	63,848	0		1.00
	TOTALS		0	63,848			
500.00	Grand Total: Decreases		0	589,634			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I Date/Time Prepared: 11/24/2015 8:22 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,500	0	0	0	0	1.00
2.00	Land Improvements	304,991	0	0	0	112,413	2.00
3.00	Buildings and Fixtures	11,525,515	0	0	0	2,643,526	3.00
4.00	Building Improvements	0	983,009	0	983,009	0	4.00
5.00	Fixed Equipment	6,841,899	0	0	0	3,967,487	5.00
6.00	Movable Equipment	0	6,589,201	0	6,589,201	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,674,905	7,572,210	0	7,572,210	6,723,426	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	18,674,905	7,572,210	0	7,572,210	6,723,426	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,500	0	1.00
2.00	Land Improvements	192,578	0	2.00
3.00	Buildings and Fixtures	8,881,989	0	3.00
4.00	Building Improvements	983,009	0	4.00
5.00	Fixed Equipment	2,874,412	0	5.00
6.00	Movable Equipment	6,589,201	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,523,689	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	19,523,689	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II Date/Time Prepared: 11/24/2015 8:22 am

	Cost Center Description	SUMMARY OF CAPITAL Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	240,974	0	271,969	79	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	444,300	150,513	0	1,041	0	2.00
2.01	CAP REL COSTS-MOB	0	209,475	0	0	0	2.01
3.00	Total (sum of lines 1-2)	685,274	359,988	271,969	1,120	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	513,022	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	595,854	2.00
2.01	CAP REL COSTS-MOB	0	209,475	2.01
3.00	Total (sum of lines 1-2)	0	1,318,351	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 11/24/2015 8:22 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	12,934,488	0	12,934,488	0.662502	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,589,201	0	6,589,201	0.337498	0	2.00
2.01	CAP REL COSTS-MOB	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	19,523,689	0	19,523,689	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	158,619	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	292,457	150,513	2.00
2.01	CAP REL COSTS-MOB	0	0	0	-41,810	209,475	2.01
3.00	Total (sum of lines 1-2)	0	0	0	409,266	359,988	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	91,550	79	0	0	250,248	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	168,796	1,041	0	0	612,807	2.00
2.01	CAP REL COSTS-MOB	0	0	0	0	167,665	2.01
3.00	Total (sum of lines 1-2)	260,346	1,120	0	0	1,030,720	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/24/2015 8:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-64,520	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-118,959	CAP REL COSTS-MVBLE EQUIP	2.00	9	2.00
2.01	Investment income - CAP REL COSTS-MOB (chapter 2)		0	CAP REL COSTS-MOB	2.01	0	2.01
3.00	Investment income - other (chapter 2)	B	-9,105	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-952	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,382	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-177,470			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,441,728			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-31,638	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	B	-1,746	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-7,385	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
27.01	Depreciation - CAP REL COSTS-MOB		0	CAP REL COSTS-MOB	2.01	0	27.01
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

ADJUSTMENTS TO EXPENSES | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/24/2015 8:22 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PROVIDER TAX	B	-243,480	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	ACCRUED INCENTIVE	A	-158,640	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MISC. INCOME - A&G	B	-1,516	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03			0		0.00	0	33.03
33.04			0		0.00	0	33.04
33.05	MISC. INCOME - NURSING ADMIN	B	-150	NURSING ADMINISTRATION	13.00	0	33.05
33.06			0		0.00	0	33.06
33.07			0		0.00	0	33.07
33.08	LOBBYING	A	-625	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	DONATIONS	A	-11,054	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10			0		0.00	0	33.10
33.11	NON-REIMBURSABLE ENTERTAINMENT	A	-6,868	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PHYSICIAN RECRUITMENT	A	-24,960	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13			0		0.00	0	33.13
33.14			0		0.00	0	33.14
33.15			0		0.00	0	33.15
33.16			0		0.00	0	33.16
33.17			0		0.00	0	33.17
33.18			0		0.00	0	33.18
33.19			0		0.00	0	33.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		581,278				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: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 11/24/2015 8:22 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,211,871	856,360	1.00
2.00	193.05	OTHER NON-REIMBURSABLE	HOME OFFICE	88,267	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION CHARGEBACK	138,799	138,799	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	ASCENSION CHARGEBACK	765,869	765,869	3.01
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	64,213	64,213	3.02
4.00	7.00	OPERATION OF PLANT	ASCENSION CHARGEBACK	94,937	94,937	4.00
4.01	13.00	NURSING ADMINISTRATION	ASCENSION CHARGEBACK	56	56	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	ASCENSION CHARGEBACK	44,983	44,983	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	ASCENSION CHARGEBACK	20,809	20,809	4.03
4.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE SELF-INSURANCE	849,867	929,815	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	64,520	82,355	4.05
4.06	2.00	CAP REL COSTS-MVBLE EQUIP	ASCENSION INTEREST	118,959	151,843	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	9,105	11,622	4.07
4.08	7.00	OPERATION OF PLANT	TRIMEDX	317,660	330,342	4.08
4.09	15.00	PHARMACY	TRIMEDX	767	798	4.09
4.10	30.00	ADULTS & PEDIATRICS	TRIMEDX	42,108	43,790	4.10
4.11	50.00	OPERATING ROOM	TRIMEDX	110,436	114,845	4.11
4.12	54.00	RADIOLOGY-DIAGNOSTIC	TRIMEDX	309,530	321,888	4.12
4.13	65.00	RESPIRATORY THERAPY	TRIMEDX	1,199	1,247	4.13
4.14	69.00	ELECTROCARDIOLOGY	TRIMEDX	24,267	25,236	4.14
4.15	91.00	EMERGENCY	TRIMEDX	19,711	20,498	4.15
4.16	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	198,426	34,326	4.16
5.00	0		0	5,496,359	4,054,631	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 11/24/2015 8:22 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,355,511	0		1.00
2.00	88,267	0		2.00
3.00	0	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
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	-79,948	0		4.04
4.05	-17,835	9		4.05
4.06	-32,884	9		4.06
4.07	-2,517	0		4.07
4.08	-12,682	0		4.08
4.09	-31	0		4.09
4.10	-1,682	0		4.10
4.11	-4,409	0		4.11
4.12	-12,358	0		4.12
4.13	-48	0		4.13
4.14	-969	0		4.14
4.15	-787	0		4.15
4.16	164,100	0		4.16
5.00	1,441,728			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 11/24/2015 8:22 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	551,933	0	551,933	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	27,470	27,470	0	0	0	2.00
3.00	91.00	EMERGENCY	150,000	150,000	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			729,403	177,470	551,933		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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	0		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	27,470		2.00
3.00	91.00	EMERGENCY	0	0	0	150,000		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	177,470		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/24/2015 8:22 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					312	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					12	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.21	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,253.00	3,449.00	3,646.00	4,636.00	0.00	9.00
10.00	AHSEA (see instructions)	96.92	77.54	58.15	38.77	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.77	38.77	29.08			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					121,441	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					267,435	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					212,015	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					600,891	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					179,738	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					780,629	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					780,629	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					12,096	24.00
25.00	Assistants (line 4 times column 3, line 11)					349	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					12,445	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,688	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					14,133	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					14,133	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151309	Period: From 07/01/2014 To 06/30/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/24/2015 8:22 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.54	58.15	38.77	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		780,629	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		14,133	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		794,762	63.00
64.00	Total cost of outside supplier services (from your records)		587,200	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		12,445	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,688	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		14,133	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,688	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		1,688	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/24/2015 8:22 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		50	1.00
2.00	Line 1 multiplied by 15 hours per week		750	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		196	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.21	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,209.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.50	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.75	36.75	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	88,862	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	88,862	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	88,862	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	88,862	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	7,203	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	7,203	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,021	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	8,224	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	8,224	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151309	Period: From 07/01/2014 To 06/30/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/24/2015 8:22 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.50	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		88,862	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		8,224	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		97,086	63.00
64.00	Total cost of outside supplier services (from your records)		63,848	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		7,203	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,021	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		8,224	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,021	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		1,021	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

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Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					48	1.00
2.00	Line 1 multiplied by 15 hours per week					720	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					127	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.21	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	284.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	70.65	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	35.33	35.33	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					20,065	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					20,065	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					20,065	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					70.65	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					50,868	22.00
23.00	Total salary equivalency (see instructions)					50,868	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					4,487	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					4,487	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					662	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					5,149	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					5,149	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/24/2015 8:22 am

Speech Pathology — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	70.65	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	50,868	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	5,149	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	56,017	63.00
64.00	Total cost of outside supplier services (from your records)	19,361	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	4,487	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	662	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	5,149	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	662	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	662	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/24/2015 8:22 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP	MOB		
			0	1.00	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	250,248	250,248				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	612,807		612,807			2.00
2.01	00201	CAP REL COSTS-MOB	167,665		0	167,665		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,583,024	0	0	0	1,583,024	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,327,111	93,294	223,595	32,241	445,805	5.00
7.00	00700	OPERATION OF PLANT	884,334	51,356	123,085	0	39,121	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	55,766	5,368	12,865	0	0	8.00
9.00	00900	HOUSEKEEPING	361,086	2,977	7,134	0	0	9.00
10.00	01000	DIETARY	194,721	6,612	15,847	0	0	10.00
11.00	01100	CAFETERIA	140,068	3,750	8,989	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	253,846	5,859	14,043	0	66,529	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	74,486	0	0	0	0	14.00
15.00	01500	PHARMACY	901,832	2,937	7,040	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	163,875	26,040	62,412	0	49,846	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,150,173	16,904	40,514	0	300,369	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	819,703	6,939	16,632	0	135,163	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,193,500	4,812	11,534	2,905	212,778	54.00
60.00	06000	LABORATORY	1,147,040	3,935	9,432	0	5,000	60.00
65.00	06500	RESPIRATORY THERAPY	180,289	4,746	11,374	0	41,938	65.00
66.00	06600	PHYSICAL THERAPY	629,072	0	0	22,191	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,319	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,361	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	148,255	0	0	0	34,030	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	138,923	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	191,430	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	116	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,540,051	13,924	33,373	0	252,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,196,101	249,453	597,869	57,337	1,582,897	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	643	1,542	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	35,322	0	0	110,328	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	13,032	0	0	193.01
193.02	19302	PUBLIC RELATIONS	144	152	364	0	38	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	607	0	0	0	89	193.04
193.05	19305	OTHER NON-REIMBURSABLE	88,267	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,320,441	250,248	612,807	167,665	1,583,024	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/24/2015 8:22 am

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,122,046	5,122,046				5.00
7.00	00700	OPERATION OF PLANT	1,097,896	461,001	1,558,897			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,999	31,072	72,299	177,370		8.00
9.00	00900	HOUSEKEEPING	371,197	155,864	40,093	8,122	575,276	9.00
10.00	01000	DIETARY	217,180	91,193	89,055	0	0	10.00
11.00	01100	CAFETERIA	152,807	64,163	50,515	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	340,277	142,881	78,920	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	74,486	31,276	0	0	0	14.00
15.00	01500	PHARMACY	911,809	382,864	39,562	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	302,173	126,881	350,746	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,507,960	633,185	227,686	47,420	272,256	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	978,437	410,841	93,469	33,847	137,616	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,425,529	598,572	82,761	24,918	41,351	54.00
60.00	06000	LABORATORY	1,165,407	489,349	53,008	0	41,351	60.00
65.00	06500	RESPIRATORY THERAPY	238,347	100,081	63,920	0	0	65.00
66.00	06600	PHYSICAL THERAPY	651,263	273,462	118,604	10,238	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,319	28,267	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,361	8,130	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	182,285	76,541	0	284	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	138,923	58,333	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	191,430	80,380	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	116	49	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,839,666	772,466	187,552	49,302	41,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,069,913	5,016,851	1,548,190	174,131	533,925	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,185	917	8,664	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	145,650	61,158	0	3,239	41,351	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	13,032	5,472	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	698	293	2,043	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	696	292	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	88,267	37,063	0	0	0	193.05
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,320,441	5,122,046	1,558,897	177,370	575,276	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/24/2015 8:22 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	397,428					10.00
11.00	01100	CAFETERIA	0	267,485				11.00
13.00	01300	NURSING ADMINISTRATION	0	10,877	572,955			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	105,762		14.00
15.00	01500	PHARMACY	0	0	0	0	1,334,235	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,654	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	397,428	78,461	327,039	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	31,246	65,204	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	46,726	0	0	0	54.00
60.00	06000	LABORATORY	0	2,852	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,610	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	7,211	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	105,762	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,334,235	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	57,807	180,712	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	397,428	267,444	572,955	105,762	1,334,235	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	41	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
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)	397,428	267,485	572,955	105,762	1,334,235	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/24/2015 8:22 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	800,454					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,635	3,544,070	0	3,544,070		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	97,134	1,847,794	0	1,847,794		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	259,154	2,479,011	0	2,479,011		54.00
60.00	06000	LABORATORY	142,141	1,894,108	0	1,894,108		60.00
65.00	06500	RESPIRATORY THERAPY	11,342	425,300	0	425,300		65.00
66.00	06600	PHYSICAL THERAPY	43,698	1,097,265	0	1,097,265		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,298	99,884	0	99,884		67.00
68.00	06800	SPEECH PATHOLOGY	893	28,384	0	28,384		68.00
69.00	06900	ELECTROCARDIOLOGY	27,402	293,723	0	293,723		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	303,018	0	303,018		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	271,810	0	271,810		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,334,400	0	1,334,400		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	161,757	3,290,613	0	3,290,613		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	800,454	16,909,380	0	16,909,380		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,766	0	11,766		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	251,398	0	251,398		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	18,504	0	18,504		193.01
193.02	19302	PUBLIC RELATIONS	0	3,034	0	3,034		193.02
193.03	19303	FOUNDATION	0	0	0	0		193.03
193.04	19304	MISSION SERVICES	0	1,029	0	1,029		193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	125,330	0	125,330		193.05
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	800,454	17,320,441	0	17,320,441		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/24/2015 8:22 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	CAPITAL RELATED COSTS MOB	Subtotal	
			0	1.00	2.00	2.01	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	235,929	93,294	223,595	32,241	585,059	5.00
7.00	00700	OPERATION OF PLANT	0	51,356	123,085	0	174,441	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,368	12,865	0	18,233	8.00
9.00	00900	HOUSEKEEPING	0	2,977	7,134	0	10,111	9.00
10.00	01000	DIETARY	0	6,612	15,847	0	22,459	10.00
11.00	01100	CAFETERIA	0	3,750	8,989	0	12,739	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,859	14,043	0	19,902	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	2,937	7,040	0	9,977	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,040	62,412	0	88,452	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	16,904	40,514	0	57,418	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,939	16,632	0	23,571	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,812	11,534	2,905	19,251	54.00
60.00	06000	LABORATORY	0	3,935	9,432	0	13,367	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,746	11,374	0	16,120	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	22,191	22,191	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	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	13,924	33,373	0	47,297	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	235,929	249,453	597,869	57,337	1,140,588	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	643	1,542	0	2,185	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	110,328	110,328	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	13,032	0	13,032	193.01
193.02	19302	PUBLIC RELATIONS	0	152	364	0	516	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	235,929	250,248	612,807	167,665	1,266,649	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/24/2015 8:22 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	585,059				5.00
7.00	00700	OPERATION OF PLANT	0	52,657	227,098			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,549	10,532	32,314		8.00
9.00	00900	HOUSEKEEPING	0	17,803	5,841	1,480	35,235	9.00
10.00	01000	DIETARY	0	10,416	12,973	0	0	10.00
11.00	01100	CAFETERIA	0	7,329	7,359	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	16,320	11,497	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,572	0	0	0	14.00
15.00	01500	PHARMACY	0	43,732	5,763	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,493	51,097	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	72,325	33,169	8,639	16,674	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	46,928	13,616	6,166	8,429	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	68,371	12,057	4,540	2,533	54.00
60.00	06000	LABORATORY	0	55,895	7,722	0	2,533	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,432	9,312	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	31,236	17,278	1,865	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,229	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	929	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,743	0	52	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,663	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,181	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	88,235	27,322	8,982	2,533	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	573,044	225,538	31,724	32,702	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	105	1,262	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,986	0	590	2,533	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	625	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	33	298	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	33	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	4,233	0	0	0	193.05
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)	0	585,059	227,098	32,314	35,235	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/24/2015 8:22 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	45,848					10.00
11.00	01100	CAFETERIA	0	27,427				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,115	48,834			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	3,572		14.00
15.00	01500	PHARMACY	0	0	0	0	59,472	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,118	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,848	8,047	27,875	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,204	5,557	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,791	0	0	0	54.00
60.00	06000	LABORATORY	0	292	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,190	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	739	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	3,572	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	59,472	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	5,927	15,402	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,848	27,423	48,834	3,572	59,472	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	4	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
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)	45,848	27,427	48,834	3,572	59,472	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/24/2015 8:22 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	156,160					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,268	280,263	0	280,263		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,949	126,420	0	126,420		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,562	162,105	0	162,105		54.00
60.00	06000	LABORATORY	27,729	107,538	0	107,538		60.00
65.00	06500	RESPIRATORY THERAPY	2,213	40,267	0	40,267		65.00
66.00	06600	PHYSICAL THERAPY	8,525	81,095	0	81,095		66.00
67.00	06700	OCCUPATIONAL THERAPY	838	4,067	0	4,067		67.00
68.00	06800	SPEECH PATHOLOGY	174	1,103	0	1,103		68.00
69.00	06900	ELECTROCARDIOLOGY	5,346	14,880	0	14,880		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,235	0	10,235		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,181	0	9,181		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	59,478	0	59,478		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	31,556	227,254	0	227,254		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	156,160	1,123,886	0	1,123,886		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,552	0	3,552		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	120,437	0	120,437		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	13,657	0	13,657		193.01
193.02	19302	PUBLIC RELATIONS	0	847	0	847		193.02
193.03	19303	FOUNDATION	0	0	0	0		193.03
193.04	19304	MISSION SERVICES	0	37	0	37		193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	4,233	0	4,233		193.05
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	156,160	1,266,649	0	1,266,649		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/24/2015 8:22 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	CAPITAL RELATED COSTS MOB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	2.00	2.01	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	82,473					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		84,265				2.00
2.01	00201	CAP REL COSTS-MOB		0	25,341			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	5,060,346		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,746	30,746	4,873	1,425,070	-5,122,046	5.00
7.00	00700	OPERATION OF PLANT	16,925	16,925	0	125,057	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,769	1,769	0	0	0	8.00
9.00	00900	HOUSEKEEPING	981	981	0	0	0	9.00
10.00	01000	DIETARY	2,179	2,179	0	0	0	10.00
11.00	01100	CAFETERIA	1,236	1,236	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,931	1,931	0	212,670	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	968	968	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,582	8,582	0	159,341	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,571	5,571	0	960,169	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,287	2,287	0	432,067	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,586	1,586	439	680,174	0	54.00
60.00	06000	LABORATORY	1,297	1,297	0	15,983	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,564	1,564	0	134,061	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,354	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	108,780	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,589	4,589	0	806,568	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	82,211	82,211	8,666	5,059,940	-5,122,046	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	212	212	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	16,675	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	1,792	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	50	50	0	123	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	283	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
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)	250,248	612,807	167,665	1,583,024		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.034302	7.272379	6.616353	0.312829		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/24/2015 8:22 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,198,395					5.00
7.00	00700	OPERATION OF PLANT	1,097,896	38,143				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,999	1,769	114,277			8.00
9.00	00900	HOUSEKEEPING	371,197	981	5,233	8,695		9.00
10.00	01000	DIETARY	217,180	2,179	0	0	100	10.00
11.00	01100	CAFETERIA	152,807	1,236	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	340,277	1,931	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	74,486	0	0	0	0	14.00
15.00	01500	PHARMACY	911,809	968	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	302,173	8,582	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,507,960	5,571	30,552	4,115	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	978,437	2,287	21,807	2,080	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,425,529	2,025	16,054	625	0	54.00
60.00	06000	LABORATORY	1,165,407	1,297	0	625	0	60.00
65.00	06500	RESPIRATORY THERAPY	238,347	1,564	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	651,263	2,902	6,596	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,319	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,361	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	182,285	0	183	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	138,923	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	191,430	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	116	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,839,666	4,589	31,765	625	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,947,867	37,881	112,190	8,070	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,185	212	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	145,650	0	2,087	625	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	13,032	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	698	50	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	696	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	88,267	0	0	0	0	193.05
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)	5,122,046	1,558,897	177,370	575,276	397,428	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.419895	40.869806	1.552106	66.161702	3,974.280000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	585,059	227,098	32,314	35,235	45,848	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.047962	5.953858	0.282769	4.052329	458.480000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/24/2015 8:22 am

		Cost Center Description	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	6,566					11.00
13.00	01300	NURSING ADMINISTRATION	267	4,499				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	100			14.00
15.00	01500	PHARMACY	0	0	0	1,000		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	507	0	0	0	55,947,760	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,926	2,568	0	0	3,678,938	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	767	512	0	0	6,789,272	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,147	0	0	0	18,113,148	54.00
60.00	06000	LABORATORY	70	0	0	0	9,935,055	60.00
65.00	06500	RESPIRATORY THERAPY	285	0	0	0	792,777	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	3,054,313	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	300,387	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	62,413	68.00
69.00	06900	ELECTROCARDIOLOGY	177	0	0	0	1,915,290	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,419	1,419	0	0	11,306,167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,565	4,499	100	1,000	55,947,760	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	1	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
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)	267,485	572,955	105,762	1,334,235	800,454	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.737892	127.351634	1,057.620000	1,334.235000	0.014307	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	27,427	48,834	3,572	59,472	156,160	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.177125	10.854412	35.720000	59.472000	0.002791	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,544,070		3,544,070	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,847,794		1,847,794	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,479,011		2,479,011	0	0	54.00
60.00	06000	LABORATORY	1,894,108		1,894,108	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	425,300	0	425,300	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,097,265	0	1,097,265	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,884	0	99,884	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	28,384	0	28,384	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	293,723		293,723	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	303,018		303,018	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	271,810		271,810	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,334,400		1,334,400	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,290,613		3,290,613	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	562,982		562,982		0	92.00
200.00		Subtotal (see instructions)	17,472,362	0	17,472,362	0	0	200.00
201.00		Less Observation Beds	562,982		562,982		0	201.00
202.00		Total (see instructions)	16,909,380	0	16,909,380	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,972,549		2,972,549			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	610,615	6,178,657	6,789,272	0.272164	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	892,594	17,220,554	18,113,148	0.136863	0.000000	54.00
60.00	06000	LABORATORY	763,554	9,171,501	9,935,055	0.190649	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	532,053	260,724	792,777	0.536469	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	449,000	2,605,313	3,054,313	0.359251	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	164,523	135,864	300,387	0.332518	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	15,318	47,095	62,413	0.454777	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	270,584	1,644,706	1,915,290	0.153357	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	567,221	1,184,125	1,751,346	0.173020	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	259,816	444,658	704,474	0.385834	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,409,062	2,594,728	4,003,790	0.333284	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	242,581	11,063,586	11,306,167	0.291046	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	706,389	706,389	0.796986	0.000000	92.00
200.00		Subtotal (see instructions)	9,149,470	53,257,900	62,407,370			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,149,470	53,257,900	62,407,370			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
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: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/24/2015 8:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,544,070		3,544,070	0	3,544,070	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,847,794		1,847,794	0	1,847,794	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,479,011		2,479,011	0	2,479,011	54.00
60.00	06000	LABORATORY	1,894,108		1,894,108	0	1,894,108	60.00
65.00	06500	RESPIRATORY THERAPY	425,300	0	425,300	0	425,300	65.00
66.00	06600	PHYSICAL THERAPY	1,097,265	0	1,097,265	0	1,097,265	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,884	0	99,884	0	99,884	67.00
68.00	06800	SPEECH PATHOLOGY	28,384	0	28,384	0	28,384	68.00
69.00	06900	ELECTROCARDIOLOGY	293,723		293,723	0	293,723	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	303,018		303,018	0	303,018	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	271,810		271,810	0	271,810	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,334,400		1,334,400	0	1,334,400	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,290,613		3,290,613	0	3,290,613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	562,982		562,982		562,982	92.00
200.00		Subtotal (see instructions)	17,472,362	0	17,472,362	0	17,472,362	200.00
201.00		Less Observation Beds	562,982		562,982		562,982	201.00
202.00		Total (see instructions)	16,909,380	0	16,909,380	0	16,909,380	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/24/2015 8:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,972,549		2,972,549			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	610,615	6,178,657	6,789,272	0.272164	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	892,594	17,220,554	18,113,148	0.136863	0.000000	54.00
60.00	06000	LABORATORY	763,554	9,171,501	9,935,055	0.190649	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	532,053	260,724	792,777	0.536469	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	449,000	2,605,313	3,054,313	0.359251	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	164,523	135,864	300,387	0.332518	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	15,318	47,095	62,413	0.454777	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	270,584	1,644,706	1,915,290	0.153357	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	567,221	1,184,125	1,751,346	0.173020	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	259,816	444,658	704,474	0.385834	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,409,062	2,594,728	4,003,790	0.333284	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	242,581	11,063,586	11,306,167	0.291046	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	706,389	706,389	0.796986	0.000000	92.00
200.00		Subtotal (see instructions)	9,149,470	53,257,900	62,407,370			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,149,470	53,257,900	62,407,370			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/24/2015 8:22 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
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: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	126,420	6,789,272	0.018621	285,119	5,309	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	162,105	18,113,148	0.008950	381,049	3,410	54.00
60.00	06000	LABORATORY	107,538	9,935,055	0.010824	457,157	4,948	60.00
65.00	06500	RESPIRATORY THERAPY	40,267	792,777	0.050792	235,421	11,958	65.00
66.00	06600	PHYSICAL THERAPY	81,095	3,054,313	0.026551	94,913	2,520	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,067	300,387	0.013539	28,368	384	67.00
68.00	06800	SPEECH PATHOLOGY	1,103	62,413	0.017673	6,951	123	68.00
69.00	06900	ELECTROCARDIOLOGY	14,880	1,915,290	0.007769	144,276	1,121	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,235	1,751,346	0.005844	264,230	1,544	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,181	704,474	0.013032	107,813	1,405	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,478	4,003,790	0.014855	640,781	9,519	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	227,254	11,306,167	0.020100	21,791	438	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	63,482	706,389	0.089868	0	0	92.00
200.00		Total (lines 50-199)	907,105	59,434,821		2,667,869	42,679	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,789,272	0.000000	0.000000	285,119	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,113,148	0.000000	0.000000	381,049	54.00
60.00	06000	LABORATORY	0	9,935,055	0.000000	0.000000	457,157	60.00
65.00	06500	RESPIRATORY THERAPY	0	792,777	0.000000	0.000000	235,421	65.00
66.00	06600	PHYSICAL THERAPY	0	3,054,313	0.000000	0.000000	94,913	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	300,387	0.000000	0.000000	28,368	67.00
68.00	06800	SPEECH PATHOLOGY	0	62,413	0.000000	0.000000	6,951	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,915,290	0.000000	0.000000	144,276	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,751,346	0.000000	0.000000	264,230	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	704,474	0.000000	0.000000	107,813	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,003,790	0.000000	0.000000	640,781	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	11,306,167	0.000000	0.000000	21,791	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	706,389	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	59,434,821			2,667,869	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.272164	0	2,368,929	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136863	0	5,499,572	0	0	54.00
60.00	06000	LABORATORY	0.190649	0	3,371,469	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.536469	0	101,048	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.359251	0	876,982	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.332518	0	32,659	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.454777	0	18,611	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153357	0	307,461	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173020	0	543,747	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.385834	0	319,987	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333284	0	1,112,294	7,961	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.291046	0	2,767,371	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.796986	0	344,268	0	0	92.00
200.00		Subtotal (see instructions)		0	17,664,398	7,961	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	17,664,398	7,961	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	644,737	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	752,688	0		54.00
60.00	06000	LABORATORY	642,767	0		60.00
65.00	06500	RESPIRATORY THERAPY	54,209	0		65.00
66.00	06600	PHYSICAL THERAPY	315,057	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	10,860	0		67.00
68.00	06800	SPEECH PATHOLOGY	8,464	0		68.00
69.00	06900	ELECTROCARDIOLOGY	47,151	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	94,079	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	123,462	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	370,710	2,653		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	805,432	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	274,377	0		92.00
200.00		Subtotal (see instructions)	4,143,993	2,653		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,143,993	2,653		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151309 | Component CCN: 15Z309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.272164	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136863	0	0	0	0	54.00
60.00	06000	LABORATORY	0.190649	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.536469	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.359251	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.332518	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.454777	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153357	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173020	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.385834	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333284	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.291046	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.796986	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151309 | Component CCN: 15Z309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151309	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/24/2015 8:22 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,252	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,203	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,704	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	462	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)	462	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	59	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)	66	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,032	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)	462	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)	462	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,544,070	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)	7,619	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)	8,523	25.00
26.00	Total swing-bed cost (see instructions)	1,058,608	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,485,462	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,485,462	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,128.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,164,313	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)	1,164,313	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	719,241	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,883,554	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	521,233	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	521,233	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,042,466	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	499	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,128.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	562,982	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	280,263	2,485,462	0.112761	562,982	63,482	90.00
91.00	Nursing School cost	0	2,485,462	0.000000	562,982	0	91.00
92.00	Allied health cost	0	2,485,462	0.000000	562,982	0	92.00
93.00	All other Medical Education	0	2,485,462	0.000000	562,982	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/24/2015 8:22 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,252	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,203	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,704	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	391	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)	533	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	31	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)	94	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	77	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,544,070	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)	1,047,243	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,496,827	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,496,827	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,133.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	87,270	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)	87,270	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/24/2015 8:22 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	186,101	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	273,371	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	499	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,133.38	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	565,557	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/24/2015 8:22 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	280,263	2,496,827	0.112248	565,557	63,483	90.00
91.00	Nursing School cost	0	2,496,827	0.000000	565,557	0	91.00
92.00	Allied health cost	0	2,496,827	0.000000	565,557	0	92.00
93.00	All other Medical Education	0	2,496,827	0.000000	565,557	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,324,178		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.272164	285,119	77,599	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136863	381,049	52,152	54.00
60.00	06000	LABORATORY	0.190649	457,157	87,157	60.00
65.00	06500	RESPIRATORY THERAPY	0.536469	235,421	126,296	65.00
66.00	06600	PHYSICAL THERAPY	0.359251	94,913	34,098	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.332518	28,368	9,433	67.00
68.00	06800	SPEECH PATHOLOGY	0.454777	6,951	3,161	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153357	144,276	22,126	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173020	264,230	45,717	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.385834	107,813	41,598	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333284	640,781	213,562	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.291046	21,791	6,342	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.796986	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,667,869	719,241	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		2,667,869		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151309 | Component CCN: 15Z309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.272164	2,391	651	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136863	35,161	4,812	54.00
60.00	06000	LABORATORY	0.190649	100,747	19,207	60.00
65.00	06500	RESPIRATORY THERAPY	0.536469	116,426	62,459	65.00
66.00	06600	PHYSICAL THERAPY	0.359251	276,371	99,287	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.332518	106,276	35,339	67.00
68.00	06800	SPEECH PATHOLOGY	0.454777	1,913	870	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153357	2,706	415	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173020	96,385	16,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.385834	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333284	203,444	67,805	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.291046	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.796986	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		941,820	307,522	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		941,820		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/24/2015 8:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		247,490		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.272164	109,463	29,792	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136863	121,622	16,646	54.00
60.00	06000	LABORATORY	0.190649	104,957	20,010	60.00
65.00	06500	RESPIRATORY THERAPY	0.536469	38,127	20,454	65.00
66.00	06600	PHYSICAL THERAPY	0.359251	7,365	2,646	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.332518	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.454777	1,230	559	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153357	15,553	2,385	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173020	70,564	12,209	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.385834	152,003	58,648	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333284	68,265	22,752	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.291046	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.796986	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		689,149	186,101	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		689,149		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151309	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/24/2015 8:22 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,146,646	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)	4,146,646	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,188,112	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	46,801	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,872,825	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)	1,268,486	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)	1,268,486	30.00
31.00	Primary payer payments	966	31.00
32.00	Subtotal (line 30 minus line 31)	1,267,520	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	700,018	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	532,014	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	437,446	36.00
37.00	Subtotal (see instructions)	1,799,534	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,799,534	40.00
40.01	Sequestration adjustment (see instructions)	35,991	40.01
41.00	Interim payments	2,062,001	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-298,458	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,652,732		2,062,001	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	02/05/2015	83,300		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
	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)		83,300		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)		1,736,032		2,062,001	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		90,235		298,458	6.02
7.00	Total Medicare program liability (see instructions)		1,645,797		1,763,543	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151309 | Component CCN: 15Z309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/24/2015 8:22 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,310,047		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,310,047		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		6,620		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,316,667		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: 151309 Component CCN: 15Z309	Period: From 07/01/2014 To 06/30/2015	Worksheet E-2 Date/Time Prepared: 11/24/2015 8:22 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,052,891	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	310,597	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	924	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,363,488	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,363,488	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,363,488	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	23,722	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,339,766	0	15.00
16.00		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	5,803	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	3,772	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,343,538	0	19.00
19.01	Sequestration adjustment (see instructions)	26,871	0	19.01
20.00	Interim payments	1,310,047	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	6,620	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151309	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part V Date/Time Prepared: 11/24/2015 8:22 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,883,554	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,883,554	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,902,390	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,902,390	19.00
20.00	Deductibles (exclude professional component)	264,662	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,637,728	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,637,728	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	54,812	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	41,657	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	16,275	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,679,385	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)	1,679,385	30.00
30.01	Sequestration adjustment (see instructions)	33,588	30.01
31.00	Interim payments	1,736,032	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)	-90,235	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: 151309	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 11/24/2015 8:22 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	273,371		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)	273,371	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)	273,371	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	247,490		8.00
9.00	Ancillary service charges	689,149	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)	936,639	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	936,639	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	663,268	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)	273,371	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	273,371	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	273,371	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	273,371	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	273,371	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)	273,371	0	40.00
41.00	Interim payments	273,371	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 11/24/2015 8:22 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,044,576	0	0	0	1.00
2.00	Temporary investments	121,282	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,965,662	0	0	0	4.00
5.00	Other receivable	313,853	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,389,621	0	0	0	6.00
7.00	Inventory	459,635	0	0	0	7.00
8.00	Prepaid expenses	231,547	0	0	0	8.00
9.00	Other current assets	-158,207	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,588,727	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,500	0	0	0	12.00
13.00	Land improvements	192,578	0	0	0	13.00
14.00	Accumulated depreciation	-188,636	0	0	0	14.00
15.00	Buildings	8,881,989	0	0	0	15.00
16.00	Accumulated depreciation	-3,703,936	0	0	0	16.00
17.00	Leasehold improvements	983,009	0	0	0	17.00
18.00	Accumulated depreciation	-432,625	0	0	0	18.00
19.00	Fixed equipment	2,874,412	0	0	0	19.00
20.00	Accumulated depreciation	-2,332,383	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,589,201	0	0	0	23.00
24.00	Accumulated depreciation	-5,561,136	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)	7,304,973	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	35,780,731	1,779,536	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	35,780,731	1,779,536	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	47,674,431	1,779,536	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	663,381	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,080,907	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	95,879	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,559,927	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,400,094	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,674,769	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	53,788	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	7,728,557	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	11,128,651	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	36,545,780				52.00
53.00	Specific purpose fund		1,779,536			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	36,545,780	1,779,536	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	47,674,431	1,779,536	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 11/24/2015 8:22 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		38,117,098		1,773,368		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,818,959				2.00
3.00	Total (sum of line 1 and line 2)		41,936,057		1,773,368		3.00
4.00	DEFERRED PENSION COSTS	0		0		0	4.00
5.00	CONTRIBUTIONS	0		61,261		0	5.00
6.00	RESTRICTED INVEST. INCOME - HSD	0		40,865		0	6.00
7.00	RESTRICTED INVEST. INCOME NON-HSD	0		0		0	7.00
8.00	OTHER RESTRICTED ACTIVITY	0		0		0	8.00
9.00	UNREALIZED LOSS-RESTR. HSD & NON HSD	0		2,964		0	9.00
10.00	Total additions (sum of line 4-9)		0		105,090		10.00
11.00	Subtotal (line 3 plus line 10)		41,936,057		1,878,458		11.00
12.00	TRANSFERS TO AFFILIATES	5,032,158		0		0	12.00
13.00	NET ASSETS RELEASED FROM RESTRI - OP	0		36,083		0	13.00
14.00	RESTRICTED INVEST. INCOME - NON-HSD	0		8,758		0	14.00
15.00	UNREALIZED LOSSES RESTR. HSD	0		54,081		0	15.00
16.00	PENSION COST ADJUSTMENT	358,120		0		0	16.00
17.00	ROUNDING	-1		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		5,390,277		98,922		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		36,545,780		1,779,536		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	DEFERRED PENSION COSTS		0			4.00
5.00	CONTRIBUTIONS		0			5.00
6.00	RESTRICTED INVEST. INCOME - HSD		0			6.00
7.00	RESTRICTED INVEST. INCOME NON-HSD		0			7.00
8.00	OTHER RESTRICTED ACTIVITY		0			8.00
9.00	UNREALIZED LOSS-RESTR. HSD & NON HSD		0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	TRANSFERS TO AFFILIATES		0			12.00
13.00	NET ASSETS RELEASED FROM RESTRI - OP		0			13.00
14.00	RESTRICTED INVEST. INCOME - NON-HSD		0			14.00
15.00	UNREALIZED LOSSES RESTR. HSD		0			15.00
16.00	PENSION COST ADJUSTMENT		0			16.00
17.00	ROUNDING		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: 151309 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/24/2015 8:22 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,126,872		3,126,872	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)	3,126,872		3,126,872	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)	3,126,872		3,126,872	17.00
18.00	Ancillary services	5,832,918	41,455,349	47,288,267	18.00
19.00	Outpatient services	242,581	11,749,651	11,992,232	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	ANESTHESIOLOGY	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,202,371	53,205,000	62,407,371	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,739,163		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)		16,739,163		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151309	Period: From 07/01/2014 To 06/30/2015	Worksheet G-3 Date/Time Prepared: 11/24/2015 8:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	62,407,371	1.00
2.00	Less contractual allowances and discounts on patients' accounts	41,690,482	2.00
3.00	Net patient revenues (line 1 minus line 2)	20,716,889	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,739,163	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,977,726	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,069,660	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	31,638	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	317	16.00
17.00	Revenue from sale of drugs to other than patients	1,746	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	123,003	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	9,052	24.00
24.01	ASSETS RELEASED FROM RESTRICTION	36,083	24.01
24.02	LOSS ON INTEREST RATE SWAPS	-755	24.02
24.03	UNREALIZED LOSS	-1,414,979	24.03
24.04		0	24.04
24.05		0	24.05
25.00	Total other income (sum of lines 6-24)	-144,235	25.00
26.00	Total (line 5 plus line 25)	3,833,491	26.00
27.00		0	27.00
27.01	FUNDRAISING EXPENSES	14,532	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	14,532	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,818,959	29.00