

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: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 6/2/2014 3:56 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 6/2/2014	Time: 3:56 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SCOTT MEMORIAL HOSPITAL (151334) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 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 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-27,421	21,201	627,960	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	41,061	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	13,640	21,201	627,960	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151334		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 6/2/2014 3:43 pm				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1451 NORTH GARDNER	PO Box:								
2.00	City: SCOTTSBURG	State: IN		Zip Code: 47170-		County: SCOTT				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
1.00		2.00		3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	SCOTT MEMORIAL HOSPITAL		151334	99915	1	07/01/1966	N	O	P
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF	SCOTT MEMORIAL SWING BEDS		152334	99915		03/21/2013	N	O	P
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2013	12/31/2013		
21.00	Type of Control (see instructions)						4			
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			
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)									
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.						0			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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 col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 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			
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0			
						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	

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		Beginning: 1.00	Ending: 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 in effect in the cost reporting period.	0				37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N 1.00	Y/N 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	
		V 1.00	XVIII 2.00	XIX 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 Worksheet L, Part III and L-1, Parts I through 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 Worksheet D, Part III & IV and D-2, Part 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, section 2148? If yes, complete Worksheet D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part 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 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 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
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 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	

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
	1.00	2.00	3.00	4.00		
61.20	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 Non-Provider Settings						
63.00	Has your facility trained residents in non-provider 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	
64.00	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. 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 non-provider 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
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
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
			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 non-provider 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

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	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 a teaching program in the most recent cost report filed 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, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (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 a 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, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (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
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
					V		XIX
					1.00		2.00
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR 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
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				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		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

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		V	XIX			
		1.00	2.00			
107.00	Column 1: 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 would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	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	N	Y	N	
		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 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 hospital providers) based on the definition in CMS 15-1, §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.	N			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.	1			118.00	
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	101,564	0	0		
		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	
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		44H097	140.00	

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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: LIFEPOINT HOSPITALS	Contractor's Name: CAHABA GBA		Contractor's Number: 10301			
142.00	Street: 330 SEVEN SPRINGS WAY	PO Box:					
143.00	City: BRENTWOOD	State: TN		Zip Code: 37027			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?				Y	144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.				N	145.00	
				1.00			
				2.00			
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, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00	
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	Y	Y	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			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	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						
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				834,720	168.00	
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)				10/01/2012	12/29/2012	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 6/2/2014 3:43 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	Y		01/01/2013	1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/31/2013	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 Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been 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.			Y	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	05/21/2014	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: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet S-2
Part II
Date/Time Prepared:
6/2/2014 3:43 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			Y	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.				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.	CLINTON		BALLEW	41.00
42.00	Enter the employer/company name of the cost report preparer.	LI FEPOINT HOSPITALS, INC.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6159207569		CLINTON.BALLEW@LPNT.NET	43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	05/21/2014		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: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
6/2/2014 3:43 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	21	7,665	82,430.00	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)		21	7,665	82,430.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	3,578.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	86,008.00	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: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
6/2/2014 3:43 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,447	475	2,827			1.00
2.00 HMO and other (see instructions)	129	0				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	64	0	64			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	51			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,511	475	2,942			7.00
8.00 INTENSIVE CARE UNIT	140	24	280			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		263	338			13.00
14.00 Total (see instructions)	1,651	762	3,560	0.00	164.50	14.00
15.00 CAH visits	0	0	35,044			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	164.50	27.00
28.00 Observation Bed Days		190	870			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: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
6/2/2014 3:43 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	478	165	1,023	1.00
2.00 HMO and other (see instructions)			35			2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						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	478	165	1,023	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: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 6/2/2014 3:43 pm
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.299689	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,818,260	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		2,392,091	5.00
6.00	Medicaid charges		10,566,231	6.00
7.00	Medicaid cost (line 1 times line 6)		3,166,583	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)		0	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)		0	19.00
			1.00	
			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	0	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		7,379,346	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		752,790	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		6,626,556	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,985,906	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,985,906	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,985,906	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet A
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		1,040,953	1,040,953	200,351	1,241,304	1.00
2.00	00200		0	0	178,995	178,995	2.00
4.00	00400				-79,730	2,003,226	4.00
5.00	00500	92,166	1,990,790	2,082,956	-229,659	3,619,624	5.00
7.00	00700	1,377,531	2,471,752	3,849,283	-4,304	1,013,501	7.00
9.00	00900	222,696	795,109	1,017,805	0	358,649	9.00
10.00	01000	165,818	192,831	358,649	-313,546	137,979	10.00
11.00	01100	184,458	267,067	451,525	312,979	312,979	11.00
13.00	01300	0	0	0	114,945	114,945	13.00
14.00	01400	0	0	0	-317,169	128,145	14.00
15.00	01500	82,600	362,714	445,314	-561,365	209,080	15.00
16.00	01600	170,916	599,529	770,445	-3,886	482,349	16.00
16.00	01600	340,441	145,794	486,235			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,647,341	215,600	1,862,941	-258,729	1,604,212	30.00
31.00	03100	234,073	10,494	244,567	-19,574	224,993	31.00
34.00	03400	0	0	0	0	0	34.00
43.00	04300	0	0	0	133,075	133,075	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	411,690	1,032,376	1,444,066	-339,065	1,105,001	50.00
52.00	05200	0	0	0	25,746	25,746	52.00
54.00	05400	682,067	617,907	1,299,974	290,133	1,590,107	54.00
60.00	06000	520,223	503,712	1,023,935	-210,649	813,286	60.00
63.00	06300	0	122,393	122,393	4,109	126,502	63.00
65.00	06500	446,505	117,778	564,283	-241,002	323,281	65.00
66.00	06600	215	485,936	486,151	11,156	497,307	66.00
69.00	06900	0	368,801	368,801	-200,704	168,097	69.00
71.00	07100	0	0	0	845,533	845,533	71.00
72.00	07200	0	0	0	153,454	153,454	72.00
73.00	07300	0	0	0	558,044	558,044	73.00
76.00	03020	64,967	6,229	71,196	-369	70,827	76.00
76.01	03021	0	14,015	14,015	22,294	36,309	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	871,750	574,631	1,446,381	-32,887	1,413,494	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		92,000	92,000	0	92,000	113.00
118.00		7,515,457	12,028,411	19,543,868	38,176	19,582,044	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	9,108	27,322	36,430	0	36,430	190.01
192.00	19200	26,739	133,377	160,116	-159,684	432	192.00
192.01	19201	126,241	1,113,325	1,239,566	-1,239,566	0	192.01
194.00	07950	0	0	0	415,187	415,187	194.00
194.01	07951	0	0	0	40,997	40,997	194.01
194.02	07952	0	0	0	79,102	79,102	194.02
194.03	07953	0	0	0	40,239	40,239	194.03
194.04	07954	0	0	0	288,174	288,174	194.04
194.05	07955	0	0	0	497,375	497,375	194.05
200.00		7,677,545	13,302,435	20,979,980	0	20,979,980	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet A
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-785,446	455,858	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	400,005	579,000	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,003,226	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-426,356	3,193,268	5.00
7.00	00700	OPERATION OF PLANT	0	1,013,501	7.00
9.00	00900	HOUSEKEEPING	0	358,649	9.00
10.00	01000	DIETARY	-68,821	69,158	10.00
11.00	01100	CAFETERIA	0	312,979	11.00
13.00	01300	NURSING ADMINISTRATION	0	114,945	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	-4,472	123,673	14.00
15.00	01500	PHARMACY	0	209,080	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,302	469,047	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,723	1,602,489	30.00
31.00	03100	INTENSIVE CARE UNIT	0	224,993	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
43.00	04300	NURSERY	0	133,075	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-575,705	529,296	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	25,746	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-368,801	1,221,306	54.00
60.00	06000	LABORATORY	0	813,286	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	126,502	63.00
65.00	06500	RESPIRATORY THERAPY	-22,774	300,507	65.00
66.00	06600	PHYSICAL THERAPY	0	497,307	66.00
69.00	06900	ELECTROCARDIOLOGY	0	168,097	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	845,533	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	153,454	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	558,044	73.00
76.00	03020	CARDIAC REHAB	0	70,827	76.00
76.01	03021	SLEEP LAB	-8,950	27,359	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	1,413,494	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-92,000	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,968,345	17,613,699	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	MARKETING	0	36,430	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	432	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	415,187	194.00
194.01	07951	MEDICAL SPECIALTY	0	40,997	194.01
194.02	07952	MEDICAL OFFICE	0	79,102	194.02
194.03	07953	VA PROPERTY	0	40,239	194.03
194.04	07954	ALREFAI CAMPUS	0	288,174	194.04
194.05	07955	ORTHO CAMPUS	0	497,375	194.05
200.00		TOTAL (SUM OF LINES 118-199)	-1,968,345	19,011,635	200.00

RECLASSIFICATIONS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-6
Date/Time Prepared:
6/2/2014 3:43 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - LEASE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	178,226	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
TOTALS			0	178,226	
B - DIRECTOR OF NURSING					
1.00	NURSING ADMINISTRATION	13.00	100,721	0	1.00
TOTALS			100,721	0	
C - CORPORATE PAID BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	92,489	1.00
2.00	NURSING ADMINISTRATION	13.00	0	14,224	2.00
TOTALS			0	106,713	
D - CAPITAL INS RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	14,740	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	769	2.00
TOTALS			0	15,509	
E - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	127,859	185,120	1.00
TOTALS			127,859	185,120	
F - NURSERY L&D					
1.00	NURSERY	43.00	130,891	15,771	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	22,977	2,769	2.00
TOTALS			153,868	18,540	
G - RESP THERAPY TO EKG					
1.00	ELECTROCARDIOLOGY	69.00	140,188	36,978	1.00
TOTALS			140,188	36,978	
H - MED SUPPLIES, DRUGS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	845,533	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	153,454	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	558,044	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
TOTALS			0	1,557,031	
I - COST TO CHARGE					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	7,179	1,802	1.00
2.00	LABORATORY	60.00	16,885	5,793	2.00
3.00	BLOOD STORING, PROCESSING & TRANS.	63.00	3,298	811	3.00
4.00	PHYSICAL THERAPY	66.00	10,971	2,299	4.00
5.00	SLEEP LAB	76.01	3,075	19,219	5.00
6.00	EMERGENCY	91.00	8,175	1,254	6.00
TOTALS			49,583	31,178	
J - PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	174,850	1.00
TOTALS			0	174,850	
K - SCOTT PHYSICIAN GROUP DIRECT EXPENSE					
1.00	MEDICAL SPECIALTY	194.01		1,086	1.00
2.00	BUHSE CAMPUS	194.00	43,953	371,234	2.00
3.00	ALREFAI CAMPUS	194.04	49,055	239,119	3.00
4.00	ORTHO CAMPUS	194.05	33,233	464,142	4.00
TOTALS			126,241	1,075,581	
L - SCOTT PHYSICIAN GROUP - OVERHEAD EXP					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	10,761	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	26,983	2.00
TOTALS			0	37,744	

RECLASSIFICATIONS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-6

Date/Time Prepared:
6/2/2014 3:43 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
M - SCOTT PHYS GRP DIRECT EXP RECLASS #2					
1.00	MEDICAL SPECIALTY	194.01	26,739	13,172	1.00
2.00	MEDICAL OFFICE	194.02	0	76,963	2.00
3.00	VA PROPERTY	194.03	0	40,239	3.00
	TOTALS		26,739	130,374	
N - MISCELLANEOUS					
1.00	MEDICAL OFFICE	194.02	0	2,571	1.00
	TOTALS		0	2,571	
O - EKG TO RADIOLOGY					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	368,101	1.00
	TOTALS		0	368,101	
500.00	Grand Total: Increases		725,199	3,918,516	500.00

RECLASSIFICATIONS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-6
Date/Time Prepared:
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - LEASE RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	31,068	10		1.00
2.00	OPERATION OF PLANT	7.00	0	4,304	0		2.00
3.00	DIETARY	10.00	0	567	0		3.00
4.00	CENTRAL SERVICE & SUPPLY	14.00	0	2,617	0		4.00
5.00	PHARMACY	15.00	0	7,282	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,886	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	32,826	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	1,854	0		8.00
9.00	OPERATING ROOM	50.00	0	59,191	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,853	0		10.00
11.00	LABORATORY	60.00	0	1,542	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	12,135	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	1,792	0		13.00
14.00	EMERGENCY	91.00	0	16,309	0		14.00
	TOTALS		0	178,226			
B - DIRECTOR OF NURSING							
1.00	ADMINISTRATIVE & GENERAL	5.00	100,721	0	0		1.00
	TOTALS		100,721	0			
C - CORPORATE PAID BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	106,713	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	106,713			
D - CAPITAL INS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,509	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	15,509			
E - CAFETERIA RECLASS							
1.00	DIETARY	10.00	127,859	185,120	0		1.00
	TOTALS		127,859	185,120			
F - NURSERY L&D							
1.00	ADULTS & PEDIATRICS	30.00	153,868	18,540	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		153,868	18,540			
G - RESP THERAPY TO EKG							
1.00	RESPIRATORY THERAPY	65.00	140,188	36,978	0		1.00
	TOTALS		140,188	36,978			
H - MED SUPPLIES, DRUGS							
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	314,552	0		1.00
2.00	PHARMACY	15.00	0	554,083	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	31,693	0		3.00
4.00	OPERATING ROOM	50.00	0	279,643	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	84,096	0		5.00
6.00	LABORATORY	60.00	0	231,785	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	34,049	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	322	0		8.00
9.00	CARDIAC REHAB	76.00	0	369	0		9.00
10.00	EMERGENCY	91.00	0	26,007	0		10.00
11.00	MEDICAL OFFICE	194.02	0	432	0		11.00
	TOTALS		0	1,557,031			
I - COST TO CHARGE							
1.00	ADULTS & PEDIATRICS	30.00	17,745	4,057	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	7,015	10,705	0		2.00
3.00	NURSERY	43.00	11,251	2,336	0		3.00
4.00	OPERATING ROOM	50.00	21	210	0		4.00
5.00	RESPIRATORY THERAPY	65.00	10,605	7,047	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	2,946	6,823	0		6.00
	TOTALS		49,583	31,178			
J - PROPERTY TAX							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	174,850	13		1.00
	TOTALS		0	174,850			
K - SCOTT PHYSICIAN GROUP DIRECT EXPENSE							
1.00	SCOTT PHYSICIAN GROUP	192.01	126,241	1,075,581	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		126,241	1,075,581			
L - SCOTT PHYSICIAN GROUP - OVERHEAD EXP							
1.00	SCOTT PHYSICIAN GROUP	192.01	0	37,744	10		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	37,744			

RECLASSIFICATIONS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-6

Date/Time Prepared:
6/2/2014 3:43 pm

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
M - SCOTT PHYS GRP DIRECT EXP RECLASS #2							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	26,739	130,374	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		26,739	130,374			
N - MISCELLANEOUS							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,571	0		1.00
	TOTALS		0	2,571			
O - EKG TO RADIOLOGY							
1.00	ELECTROCARDIOLOGY	69.00	0	368,101	0		1.00
	TOTALS		0	368,101			
500.00	Grand Total: Decreases		725,199	3,918,516			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-7
Part I
Date/Time Prepared:
6/2/2014 3:43 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	241,233	598,767	0	598,767	0	1.00
2.00	Land Improvements	520,508	82,852	0	82,852	370,508	2.00
3.00	Buildings and Fixtures	22,876,858	0	0	0	20,056,858	3.00
4.00	Building Improvements	-10,000	198,909	0	198,909	0	4.00
5.00	Fixed Equipment	2,445,689	296,851	0	296,851	1,847,189	5.00
6.00	Movable Equipment	14,874,599	196,164	0	196,164	14,776,298	6.00
7.00	HIT designated Assets	0	1,204,385	0	1,204,385	0	7.00
8.00	Subtotal (sum of lines 1-7)	40,948,887	2,577,928	0	2,577,928	37,050,853	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	40,948,887	2,577,928	0	2,577,928	37,050,853	10.00
	Ending Balance		Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	840,000	0				1.00
2.00	Land Improvements	232,852	0				2.00
3.00	Buildings and Fixtures	2,820,000	0				3.00
4.00	Building Improvements	188,909	0				4.00
5.00	Fixed Equipment	895,351	0				5.00
6.00	Movable Equipment	294,465	0				6.00
7.00	HIT designated Assets	1,204,385	0				7.00
8.00	Subtotal (sum of lines 1-7)	6,475,962	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	6,475,962	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-7
Part II
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,040,953	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,040,953	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,040,953				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,040,953				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-7
Part III
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	4,081,761	0	4,081,761	0.630294	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,394,201	0	2,394,201	0.369706	0	2.00
3.00	Total (sum of lines 1-2)	6,475,962	0	6,475,962	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	255,507	10,761	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	400,005	178,226	2.00
3.00	Total (sum of lines 1-2)	0	0	0	655,512	188,987	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	14,740	174,850	0	455,858	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	769	0	0	579,000	2.00
3.00	Total (sum of lines 1-2)	0	15,509	174,850	0	1,034,858	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-8

Date/Time Prepared:
6/2/2014 3:43 pm

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.		
			3.00	4.00	5.00			
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00		0	7.00
8.00 Television and radio service (chapter 21)			0		0.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-977,953					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	27,201					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-68,821	DIETARY		10.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients	B	-4,472	CENTRAL SERVICE & SUPPLY		14.00		0	17.00
18.00 Sale of medical records and abstracts	B	-13,302	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	B	-1,367	ADMINISTRATIVE & GENERAL		5.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	B	-866	ADMINISTRATIVE & GENERAL		5.00		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	A	-785,446	CAP REL COSTS-BLDG & FIXT		1.00		9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	400,005	CAP REL COSTS-MVBLE EQUIP		2.00		9	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 MISC INCOME	B	-32,314	ADMINISTRATIVE & GENERAL		5.00		0	33.00
33.01 INDIANA PROVIDER TAX	A	-505,422	ADMINISTRATIVE & GENERAL		5.00		0	33.01

Provider CCN: 151334

Period:
 From 01/01/2013
 To 12/31/2013

Worksheet A-8

Date/Time Prepared:
 6/2/2014 3:43 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
34.00	PHYSICIAN RECRUITING	A	-2,430	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	DUES AND SUBSCRIPTIONS	A	-1,577	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	LOBBYING EXP IN ASSOC DUES	A	-551	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	LEGAL FEES	A	-1,030	ADMINISTRATIVE & GENERAL	5.00	0	37.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,968,345				50.00

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

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-8-1

Date/Time Prepared:
6/2/2014 3:43 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	113.00	INTEREST EXPENSE	0	92,000	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	7,640	101,564	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	873,400	660,275	3.00
4.00	0.00	HOME OFFICE INTEREST	0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		881,040	853,839	5.00

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

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

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

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

6.00	B	0.00	LI FEPOINT HOSP	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-8-1

Date/Time Prepared:
6/2/2014 3:43 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-92,000	11		1.00
2.00	-93,924	12		2.00
3.00	213,125	0		3.00
4.00	0	0		4.00
5.00	27,201			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	HOSP MANAGEMENT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-8-2

Date/Time Prepared:
6/2/2014 3:43 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,723	1,723	0	0	0	1.00
2.00	50.00	OPERATING ROOM	575,705	575,705	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	368,801	368,801	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	28,774	22,774	0	0	0	4.00
5.00	76.01	SLEEP LAB	8,950	8,950	0	0	0	5.00
6.00	91.00	EMERGENCY	491,787	0	491,787	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,475,740	977,953	491,787			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	76.01	SLEEP LAB	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,723		1.00
2.00	50.00	OPERATING ROOM	0	0	0	575,705		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	368,801		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	22,774		4.00
5.00	76.01	SLEEP LAB	0	0	0	8,950		5.00
6.00	91.00	EMERGENCY	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	977,953		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151334		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/2/2014 3:43 pm	
				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)					0	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					0.00	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	1,844.00	5,477.50	131.00	833.00	0.00	9.00
10.00	AHSEA (see instructions)	84.74	75.96	55.27	41.45	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)	37.98	37.98	27.64			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)					156,261	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					416,071	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					7,240	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					579,572	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					34,528	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)					614,100	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)					614,100	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)					0	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)					0	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	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)					0	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: 151334				Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/2/2014 3:43 pm	
						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		0	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		0	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	0.00		0	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		0	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		0	51.00
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	75.96	55.27	41.45	0.00			0	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	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			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)							614,100	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							0	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)							614,100	63.00
64.00	Total cost of outside supplier services (from your records)							437,633	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							0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							0	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							0	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							0	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: 151334		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/2/2014 3:43 pm	
		Speech Pathology		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)					0	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					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors		Therapists		Assistants	
		1.00		2.00		3.00	
		Aides		Trainees			
		4.00		5.00			
9.00	Total hours worked	0.00	572.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	77.21	69.21	50.36	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)	34.61	34.61	25.18			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)					39,623	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					39,623	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)					39,623	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)					69.21	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					53,984	22.00
23.00	Total salary equivalency (see instructions)					53,984	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)					0	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)					0	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	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)					0	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: 151334				Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/2/2014 3:43 pm	
						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	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	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)	69.21	50.36	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)							53,984 57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							0 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)							53,984 63.00	
64.00	Total cost of outside supplier services (from your records)							31,886 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							0 100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0 100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27							0 100.02	
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							0 101.00	
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							0 101.02	
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: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	455,858	455,858			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	579,000		579,000		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,003,226	0	0	2,003,226	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,193,268	53,542	86,051	337,193	5.00
7.00 00700	OPERATION OF PLANT	1,013,501	7,579	12,180	58,812	7.00
9.00 00900	HOUSEKEEPING	358,649	3,374	5,423	43,791	9.00
10.00 01000	DIETARY	69,158	7,427	11,936	14,947	10.00
11.00 01100	CAFETERIA	312,979	7,938	12,758	33,766	11.00
13.00 01300	NURSING ADMINISTRATION	114,945	0	0	26,599	13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	123,673	0	0	21,814	14.00
15.00 01500	PHARMACY	209,080	0	0	45,137	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	469,047	5,736	9,219	89,907	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,602,489	58,946	94,736	389,727	30.00
31.00 03100	INTENSIVE CARE UNIT	224,993	2,807	4,512	59,964	31.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
43.00 04300	NURSERY	133,075	778	1,250	31,596	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	529,296	78,054	125,447	108,718	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	25,746	2,552	4,101	6,068	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,221,306	25,426	40,864	182,023	54.00
60.00 06000	LABORATORY	813,286	8,924	14,342	141,845	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	126,502	0	0	871	63.00
65.00 06500	RESPIRATORY THERAPY	300,507	11,897	19,121	78,095	65.00
66.00 06600	PHYSICAL THERAPY	497,307	12,101	19,448	2,954	66.00
69.00 06900	ELECTROCARDIOLOGY	168,097	0	0	36,244	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	845,533	6,223	10,002	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	153,454	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	558,044	1,660	2,667	0	73.00
76.00 03020	CARDIAC REHAB	70,827	2,655	4,268	17,157	76.00
76.01 03021	SLEEP LAB	27,359	2,821	4,534	812	76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	1,413,494	25,889	41,608	232,379	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	17,613,699	326,329	524,467	1,960,419	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,296	3,690	0	190.00
190.01 19001	MARKETING	36,430	0	0	2,405	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	432	0	0	0	192.00
192.01 19201	SCOTT PHYSICIAN GROUP	0	0	0	0	192.01
194.00 07950	BUHSE CAMPUS	415,187	4,183	6,724	11,608	194.00
194.01 07951	MEDICAL SPECIALTY	40,997	8,367	13,447	7,062	194.01
194.02 07952	MEDICAL OFFICE	79,102	61,024	0	0	194.02
194.03 07953	VA PROPERTY	40,239	34,574	0	0	194.03
194.04 07954	ALREFAI CAMPUS	288,174	12,170	19,559	12,955	194.04
194.05 07955	ORTHO CAMPUS	497,375	6,915	11,113	8,777	194.05
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	19,011,635	455,858	579,000	2,003,226	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA		
		5.00	7.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	3,670,054				5.00	
7.00	00700	OPERATION OF PLANT	261,249	1,353,321			7.00	
9.00	00900	HOUSEKEEPING	98,377	11,569	521,183		9.00	
10.00	01000	DIETARY	24,752	25,461	0	153,681	10.00	
11.00	01100	CAFETERIA	87,900	27,216	9,075	0	491,632	11.00
13.00	01300	NURSING ADMINISTRATION	33,861	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	34,804	0	0	0	12,669	14.00
15.00	01500	PHARMACY	60,815	0	0	0	10,624	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	137,292	19,665	9,075	0	37,474	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	513,343	202,090	113,443	145,459	126,365	30.00
31.00	03100	INTENSIVE CARE UNIT	69,919	9,625	20,095	8,222	15,665	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00	04300	NURSERY	39,878	2,667	14,261	0	10,780	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	201,310	267,602	88,160	0	33,723	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,202	8,748	39,542	0	1,891	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	351,567	87,170	31,764	0	54,121	54.00
60.00	06000	LABORATORY	234,055	30,594	24,309	0	53,924	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	30,471	0	0	0	311	63.00
65.00	06500	RESPIRATORY THERAPY	97,991	40,788	12,317	0	26,016	65.00
66.00	06600	PHYSICAL THERAPY	127,221	41,487	15,558	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	48,883	0	12,965	0	10,994	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	206,152	21,336	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,710	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	134,532	5,690	6,806	0	0	73.00
76.00	03020	CARDIAC REHAB	22,704	9,103	4,862	0	4,476	76.00
76.01	03021	SLEEP LAB	8,499	9,672	9,399	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	409,878	88,759	103,718	0	73,254	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,281,365	909,242	515,349	153,681	472,287	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,432	7,871	5,834	0	0	190.00
190.01	19001	MARKETING	9,290	0	0	0	886	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	103	0	0	0	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	104,708	14,343	0	0	6,426	194.00
194.01	07951	MEDICAL SPECIALTY	16,715	28,685	0	0	0	194.01
194.02	07952	MEDICAL OFFICE	33,521	209,214	0	0	0	194.02
194.03	07953	VA PROPERTY	17,897	118,535	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	79,627	41,724	0	0	7,173	194.04
194.05	07955	ORTHO CAMPUS	125,396	23,707	0	0	4,860	194.05
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)	3,670,054	1,353,321	521,183	153,681	491,632	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	175,405					13.00
14.00	01400	0	192,960				14.00
15.00	01500	0	0	325,656			15.00
16.00	01600	0	0	0	777,415		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	87,703	3,610	1,161	28,544	3,367,616	30.00
31.00	03100	7,674	0	0	3,971	427,447	31.00
34.00	03400	0	0	0	0	0	34.00
43.00	04300	0	0	0	3,033	237,318	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	23,612	22,205	272	71,655	1,550,054	50.00
52.00	05200	0	0	0	7,221	105,071	52.00
54.00	05400	0	10,193	158	211,706	2,216,298	54.00
60.00	06000	0	28,185	0	151,819	1,501,283	60.00
63.00	06300	0	0	0	2,032	160,187	63.00
65.00	06500	0	4,140	0	28,575	619,447	65.00
66.00	06600	0	39	0	32,090	748,205	66.00
69.00	06900	0	0	0	19,304	296,487	69.00
71.00	07100	0	102,815	0	31,179	1,223,240	71.00
72.00	07200	0	18,660	0	6,089	214,913	72.00
73.00	07300	0	0	323,361	74,442	1,107,202	73.00
76.00	03020	12,649	45	0	2,270	151,016	76.00
76.01	03021	0	0	0	10,177	73,273	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	43,767	3,015	704	93,308	2,529,773	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		175,405	192,907	325,656	777,415	16,528,830	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	21,123	190.00
190.01	19001	0	0	0	0	49,011	190.01
192.00	19200	0	53	0	0	588	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	563,179	194.00
194.01	07951	0	0	0	0	115,273	194.01
194.02	07952	0	0	0	0	382,861	194.02
194.03	07953	0	0	0	0	211,245	194.03
194.04	07954	0	0	0	0	461,382	194.04
194.05	07955	0	0	0	0	678,143	194.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		175,405	192,960	325,656	777,415	19,011,635	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
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 SERVICE & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03020	CARDIAC REHAB	0	76.00
76.01	03021	SLEEP LAB	0	76.01
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
190.01	19001	MARKETING	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	192.01
194.00	07950	BUHSE CAMPUS	0	194.00
194.01	07951	MEDICAL SPECIALTY	0	194.01
194.02	07952	MEDICAL OFFICE	0	194.02
194.03	07953	VA PROPERTY	0	194.03
194.04	07954	ALREFAI CAMPUS	0	194.04
194.05	07955	ORTHO CAMPUS	0	194.05
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet B
Part II
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	174,050	53,542	86,051	313,643	5.00
7.00 00700	OPERATION OF PLANT	0	7,579	12,180	19,759	7.00
9.00 00900	HOUSEKEEPING	0	3,374	5,423	8,797	9.00
10.00 01000	DIETARY	0	7,427	11,936	19,363	10.00
11.00 01100	CAFETERIA	0	7,938	12,758	20,696	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	5,736	9,219	14,955	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	58,946	94,736	153,682	30.00
31.00 03100	INTENSIVE CARE UNIT	0	2,807	4,512	7,319	31.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
43.00 04300	NURSERY	0	778	1,250	2,028	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	78,054	125,447	203,501	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	2,552	4,101	6,653	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	25,426	40,864	66,290	54.00
60.00 06000	LABORATORY	0	8,924	14,342	23,266	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00 06500	RESPIRATORY THERAPY	0	11,897	19,121	31,018	65.00
66.00 06600	PHYSICAL THERAPY	0	12,101	19,448	31,549	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,223	10,002	16,225	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	1,660	2,667	4,327	73.00
76.00 03020	CARDIAC REHAB	0	2,655	4,268	6,923	76.00
76.01 03021	SLEEP LAB	0	2,821	4,534	7,355	76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	25,889	41,608	67,497	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	174,050	326,329	524,467	1,024,846	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,296	3,690	5,986	190.00
190.01 19001	MARKETING	0	0	0	0	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	SCOTT PHYSICIAN GROUP	0	0	0	0	192.01
194.00 07950	BUHSE CAMPUS	0	4,183	6,724	10,907	194.00
194.01 07951	MEDICAL SPECIALTY	0	8,367	13,447	21,814	194.01
194.02 07952	MEDICAL OFFICE	0	61,024	0	61,024	194.02
194.03 07953	VA PROPERTY	0	34,574	0	34,574	194.03
194.04 07954	ALREFAI CAMPUS	0	12,170	19,559	31,729	194.04
194.05 07955	ORTHO CAMPUS	0	6,915	11,113	18,028	194.05
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	174,050	455,858	579,000	1,208,908	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet B
Part II
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	7.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	313,643					5.00
7.00	00700	22,326	42,085				7.00
9.00	00900	8,407	360	17,564			9.00
10.00	01000	2,115	792	0	22,270		10.00
11.00	01100	7,512	846	306	0	29,360	11.00
13.00	01300	2,894	0	0	0	0	13.00
14.00	01400	2,974	0	0	0	757	14.00
15.00	01500	5,197	0	0	0	634	15.00
16.00	01600	11,733	612	306	0	2,238	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	43,875	6,285	3,823	21,078	7,546	30.00
31.00	03100	5,975	299	677	1,192	935	31.00
34.00	03400	0	0	0	0	0	34.00
43.00	04300	3,408	83	481	0	644	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	17,204	8,321	2,971	0	2,014	50.00
52.00	05200	786	272	1,333	0	113	52.00
54.00	05400	30,045	2,711	1,070	0	3,232	54.00
60.00	06000	20,002	951	819	0	3,220	60.00
63.00	06300	2,604	0	0	0	19	63.00
65.00	06500	8,374	1,268	415	0	1,554	65.00
66.00	06600	10,872	1,290	524	0	0	66.00
69.00	06900	4,178	0	437	0	657	69.00
71.00	07100	17,618	664	0	0	0	71.00
72.00	07200	3,137	0	0	0	0	72.00
73.00	07300	11,497	177	229	0	0	73.00
76.00	03020	1,940	283	164	0	267	76.00
76.01	03021	726	301	317	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	35,028	2,760	3,495	0	4,375	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		280,427	28,275	17,367	22,270	28,205	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	122	245	197	0	0	190.00
190.01	19001	794	0	0	0	53	190.01
192.00	19200	9	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	8,948	446	0	0	384	194.00
194.01	07951	1,428	892	0	0	0	194.01
194.02	07952	2,865	6,506	0	0	0	194.02
194.03	07953	1,529	3,686	0	0	0	194.03
194.04	07954	6,805	1,298	0	0	428	194.04
194.05	07955	10,716	737	0	0	290	194.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		313,643	42,085	17,564	22,270	29,360	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet B
Part II
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	2,894					13.00
14.00	01400	0	3,731				14.00
15.00	01500	0	0	5,831			15.00
16.00	01600	0	0	0	29,844		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,446	70	21	1,096	238,922	30.00
31.00	03100	127	0	0	152	16,676	31.00
34.00	03400	0	0	0	0	0	34.00
43.00	04300	0	0	0	116	6,760	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	390	429	5	2,750	237,585	50.00
52.00	05200	0	0	0	277	9,434	52.00
54.00	05400	0	197	3	8,131	111,679	54.00
60.00	06000	0	545	0	5,827	54,630	60.00
63.00	06300	0	0	0	78	2,701	63.00
65.00	06500	0	80	0	1,097	43,806	65.00
66.00	06600	0	1	0	1,232	45,468	66.00
69.00	06900	0	0	0	741	6,013	69.00
71.00	07100	0	1,988	0	1,197	37,692	71.00
72.00	07200	0	361	0	234	3,732	72.00
73.00	07300	0	0	5,789	2,857	24,876	73.00
76.00	03020	209	1	0	87	9,874	76.00
76.01	03021	0	0	0	391	9,090	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	722	58	13	3,581	117,529	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		2,894	3,730	5,831	29,844	976,467	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	6,550	190.00
190.01	19001	0	0	0	0	847	190.01
192.00	19200	0	1	0	0	10	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	20,685	194.00
194.01	07951	0	0	0	0	24,134	194.01
194.02	07952	0	0	0	0	70,395	194.02
194.03	07953	0	0	0	0	39,789	194.03
194.04	07954	0	0	0	0	40,260	194.04
194.05	07955	0	0	0	0	29,771	194.05
200.00						0	200.00
201.00		0	0	0	0	0	201.00
202.00		2,894	3,731	5,831	29,844	1,208,908	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 6/2/2014 3:43 pm
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
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 SERVICE & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	238,922
31.00	03100	INTENSIVE CARE UNIT	0	16,676
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0
43.00	04300	NURSERY	0	6,760
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	237,585
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,434
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	111,679
60.00	06000	LABORATORY	0	54,630
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,701
65.00	06500	RESPIRATORY THERAPY	0	43,806
66.00	06600	PHYSICAL THERAPY	0	45,468
69.00	06900	ELECTROCARDIOLOGY	0	6,013
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	37,692
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,732
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,876
76.00	03020	CARDIAC REHAB	0	9,874
76.01	03021	SLEEP LAB	0	9,090
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	117,529
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	976,467
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,550
190.01	19001	MARKETING	0	847
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10
192.01	19201	SCOTT PHYSICIAN GROUP	0	0
194.00	07950	BUHSE CAMPUS	0	20,685
194.01	07951	MEDICAL SPECIALTY	0	24,134
194.02	07952	MEDICAL OFFICE	0	70,395
194.03	07953	VA PROPERTY	0	39,789
194.04	07954	ALREFAI CAMPUS	0	40,260
194.05	07955	ORTHO CAMPUS	0	29,771
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	1,208,908

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet B-1
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	131,849				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		104,199			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,585,379		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	15,486	15,486	1,276,810	-3,670,054	15,341,581
7.00 00700	OPERATION OF PLANT	2,192	2,192	222,696	0	1,092,072
9.00 00900	HOUSEKEEPING	976	976	165,818	0	411,237
10.00 01000	DIETARY	2,148	2,148	56,599	0	103,468
11.00 01100	CAFETERIA	2,296	2,296	127,859	0	367,441
13.00 01300	NURSING ADMINISTRATION	0	0	100,721	0	141,544
14.00 01400	CENTRAL SERVICE & SUPPLY	0	0	82,600	0	145,487
15.00 01500	PHARMACY	0	0	170,916	0	254,217
16.00 01600	MEDICAL RECORDS & LIBRARY	1,659	1,659	340,441	0	573,909
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	17,049	17,049	1,475,728	0	2,145,898
31.00 03100	INTENSIVE CARE UNIT	812	812	227,058	0	292,276
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
43.00 04300	NURSERY	225	225	119,640	0	166,699
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	22,576	22,576	411,669	0	841,515
52.00 05200	DELIVERY ROOM & LABOR ROOM	738	738	22,977	0	38,467
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,354	7,354	689,246	0	1,469,619
60.00 06000	LABORATORY	2,581	2,581	537,108	0	978,397
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	3,298	0	127,373
65.00 06500	RESPIRATORY THERAPY	3,441	3,441	295,712	0	409,620
66.00 06600	PHYSICAL THERAPY	3,500	3,500	11,186	0	531,810
69.00 06900	ELECTROCARDIOLOGY	0	0	137,242	0	204,341
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,800	1,800	0	0	861,758
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	153,454
73.00 07300	DRUGS CHARGED TO PATIENTS	480	480	0	0	562,371
76.00 03020	CARDIAC REHAB	768	768	64,967	0	94,907
76.01 03021	SLEEP LAB	816	816	3,075	0	35,526
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	7,488	7,488	879,925	0	1,713,370
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	94,385	94,385	7,423,291	-3,670,054	13,716,776
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	664	664	0	0	5,986
190.01 19001	MARKETING	0	0	9,108	0	38,835
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	432
192.01 19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0
194.00 07950	BUHSE CAMPUS	1,210	1,210	43,953	0	437,702
194.01 07951	MEDICAL SPECIALTY	2,420	2,420	26,739	0	69,873
194.02 07952	MEDICAL OFFICE	17,650	0	0	0	140,126
194.03 07953	VA PROPERTY	10,000	0	0	0	74,813
194.04 07954	ALREFAI CAMPUS	3,520	3,520	49,055	0	332,858
194.05 07955	ORTHO CAMPUS	2,000	2,000	33,233	0	524,180
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	455,858	579,000	2,003,226		3,670,054
203.00	Unit cost multiplier (Wkst. B, Part I)	3.457425	5.556675	0.264090		0.239223
204.00	Cost to be allocated (per Wkst. B, Part II)			0		313,643
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.020444

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet B-1

Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (HOURS SUPERVI)		
		7.00	9.00	10.00	11.00	13.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	114,171				7.00	
9.00	00900	HOUSEKEEPING	976	1,608			9.00	
10.00	01000	DIETARY	2,148	0	15,999		10.00	
11.00	01100	CAFETERIA	2,296	28	0	234,192	11.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,080	13.00	
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	6,035	14.00	
15.00	01500	PHARMACY	0	0	0	5,061	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	1,659	28	0	17,851	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,049	350	15,143	60,195	1,040	30.00
31.00	03100	INTENSIVE CARE UNIT	812	62	856	7,462	91	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00	04300	NURSERY	225	44	0	5,135	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	22,576	272	0	16,064	280	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	738	122	0	901	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,354	98	0	25,781	0	54.00
60.00	06000	LABORATORY	2,581	75	0	25,687	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	148	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,441	38	0	12,393	0	65.00
66.00	06600	PHYSICAL THERAPY	3,500	48	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	40	0	5,237	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,800	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	480	21	0	0	0	73.00
76.00	03020	CARDIAC REHAB	768	15	0	2,132	150	76.00
76.01	03021	SLEEP LAB	816	29	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	7,488	320	0	34,895	519	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	76,707	1,590	15,999	224,977	2,080	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	664	18	0	0	0	190.00
190.01	19001	MARKETING	0	0	0	422	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	1,210	0	0	3,061	0	194.00
194.01	07951	MEDICAL SPECIALTY	2,420	0	0	0	0	194.01
194.02	07952	MEDICAL OFFICE	17,650	0	0	0	0	194.02
194.03	07953	VA PROPERTY	10,000	0	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	3,520	0	0	3,417	0	194.04
194.05	07955	ORTHO CAMPUS	2,000	0	0	2,315	0	194.05
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)	1,353,321	521,183	153,681	491,632	175,405	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.853457	324.118781	9.605663	2.099269	84.329327	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,085	17,564	22,270	29,360	2,894	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.368614	10.922886	1.391962	0.125367	1.391346	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet B-1
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description		CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400	1,586,857			14.00
15.00	01500	0	562,005		15.00
16.00	01600	0	0	55,153,287	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	29,690	2,003	2,024,971	30.00
31.00	03100	0	0	281,732	31.00
34.00	03400	0	0	0	34.00
43.00	04300	0	0	215,145	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	182,608	470	5,083,378	50.00
52.00	05200	0	0	512,285	52.00
54.00	05400	83,823	273	15,020,723	54.00
60.00	06000	231,785	0	10,770,332	60.00
63.00	06300	0	0	144,170	63.00
65.00	06500	34,049	0	2,027,154	65.00
66.00	06600	322	0	2,276,561	66.00
69.00	06900	0	0	1,369,437	69.00
71.00	07100	845,533	0	2,211,875	71.00
72.00	07200	153,454	0	432,001	72.00
73.00	07300	0	558,044	5,281,047	73.00
76.00	03020	369	0	161,051	76.00
76.01	03021	0	0	721,947	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	24,792	1,215	6,619,478	91.00
92.00	09200				92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		1,586,425	562,005	55,153,287	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
190.01	19001	0	0	0	190.01
192.00	19200	432	0	0	192.00
192.01	19201	0	0	0	192.01
194.00	07950	0	0	0	194.00
194.01	07951	0	0	0	194.01
194.02	07952	0	0	0	194.02
194.03	07953	0	0	0	194.03
194.04	07954	0	0	0	194.04
194.05	07955	0	0	0	194.05
200.00					200.00
201.00					201.00
202.00		192,960	325,656	777,415	202.00
203.00		0.121599	0.579454	0.014096	203.00
204.00		3,731	5,831	29,844	204.00
205.00		0.002351	0.010375	0.000541	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet C
Part I
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	3,367,616		3,367,616	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	427,447		427,447	0	0	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
43.00	04300 NURSERY	237,318		237,318	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,550,054		1,550,054	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	105,071		105,071	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,216,298		2,216,298	0	0	54.00
60.00	06000 LABORATORY	1,501,283		1,501,283	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	160,187		160,187	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	619,447	0	619,447	0	0	65.00
66.00	06600 PHYSICAL THERAPY	748,205	0	748,205	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	296,487		296,487	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,223,240		1,223,240	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	214,913		214,913	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,107,202		1,107,202	0	0	73.00
76.00	03020 CARDIAC REHAB	151,016		151,016	0	0	76.00
76.01	03021 SLEEP LAB	73,273		73,273	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	2,529,773		2,529,773	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	778,998		778,998	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	17,307,828	0	17,307,828	0	0	200.00
201.00	Less Observation Beds	778,998		778,998			201.00
202.00	Total (see instructions)	16,528,830	0	16,528,830	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 6/2/2014 3:43 pm
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,607,247		1,607,247		30.00
31.00	03100	INTENSIVE CARE UNIT	281,732		281,732		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
43.00	04300	NURSERY	215,145		215,145		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,212,657	3,870,721	5,083,378	0.304926	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	251,038	261,247	512,285	0.205103	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,109,098	13,911,625	15,020,723	0.147549	54.00
60.00	06000	LABORATORY	2,380,328	8,390,004	10,770,332	0.139391	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	77,482	66,688	144,170	1.111098	63.00
65.00	06500	RESPIRATORY THERAPY	897,721	1,129,433	2,027,154	0.305575	65.00
66.00	06600	PHYSICAL THERAPY	156,204	2,120,357	2,276,561	0.328656	66.00
69.00	06900	ELECTROCARDIOLOGY	443,094	926,343	1,369,437	0.216503	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	938,722	1,273,153	2,211,875	0.553033	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	134,805	297,196	432,001	0.497483	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,169,940	3,111,107	5,281,047	0.209656	73.00
76.00	03020	CARDIAC REHAB	0	161,051	161,051	0.937691	76.00
76.01	03021	SLEEP LAB	4,336	717,611	721,947	0.101494	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	639,197	5,980,281	6,619,478	0.382171	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	68,673	349,051	417,724	1.864863	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	12,587,419	42,565,868	55,153,287		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	12,587,419	42,565,868	55,153,287		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet C
Part I
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03020	CARDIAC REHAB	0.000000		76.00
76.01	03021	SLEEP LAB	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
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: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet C
Part I
Date/Time Prepared:
6/2/2014 3:43 pm

		Title XIX		Hospital		PPS	
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	3,367,616		3,367,616	0	3,367,616	30.00
31.00	03100 INTENSIVE CARE UNIT	427,447		427,447	0	427,447	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
43.00	04300 NURSERY	237,318		237,318	0	237,318	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,550,054		1,550,054	0	1,550,054	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	105,071		105,071	0	105,071	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,216,298		2,216,298	0	2,216,298	54.00
60.00	06000 LABORATORY	1,501,283		1,501,283	0	1,501,283	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	160,187		160,187	0	160,187	63.00
65.00	06500 RESPIRATORY THERAPY	619,447	0	619,447	0	619,447	65.00
66.00	06600 PHYSICAL THERAPY	748,205	0	748,205	0	748,205	66.00
69.00	06900 ELECTROCARDIOLOGY	296,487		296,487	0	296,487	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,223,240		1,223,240	0	1,223,240	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	214,913		214,913	0	214,913	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,107,202		1,107,202	0	1,107,202	73.00
76.00	03020 CARDIAC REHAB	151,016		151,016	0	151,016	76.00
76.01	03021 SLEEP LAB	73,273		73,273	0	73,273	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	2,529,773		2,529,773	0	2,529,773	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	778,998		778,998		778,998	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	17,307,828	0	17,307,828	0	17,307,828	200.00
201.00	Less Observation Beds	778,998		778,998		778,998	201.00
202.00	Total (see instructions)	16,528,830	0	16,528,830	0	16,528,830	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet C
Part I
Date/Time Prepared:
6/2/2014 3:43 pm

		Title XIX			Hospital	PPS		
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,607,247		1,607,247			30.00
31.00	03100	INTENSIVE CARE UNIT	281,732		281,732			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
43.00	04300	NURSERY	215,145		215,145			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,212,657	3,870,721	5,083,378	0.304926	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	251,038	261,247	512,285	0.205103	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,109,098	13,911,625	15,020,723	0.147549	0.000000	54.00
60.00	06000	LABORATORY	2,380,328	8,390,004	10,770,332	0.139391	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	77,482	66,688	144,170	1.111098	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	897,721	1,129,433	2,027,154	0.305575	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	156,204	2,120,357	2,276,561	0.328656	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	443,094	926,343	1,369,437	0.216503	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	938,722	1,273,153	2,211,875	0.553033	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	134,805	297,196	432,001	0.497483	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,169,940	3,111,107	5,281,047	0.209656	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	161,051	161,051	0.937691	0.000000	76.00
76.01	03021	SLEEP LAB	4,336	717,611	721,947	0.101494	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	639,197	5,980,281	6,619,478	0.382171	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	68,673	349,051	417,724	1.864863	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,587,419	42,565,868	55,153,287			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,587,419	42,565,868	55,153,287			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 6/2/2014 3:43 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.304926		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.205103		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.147549		54.00
60.00	06000 LABORATORY	0.139391		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1.111098		63.00
65.00	06500 RESPIRATORY THERAPY	0.305575		65.00
66.00	06600 PHYSICAL THERAPY	0.328656		66.00
69.00	06900 ELECTROCARDIOLOGY	0.216503		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.553033		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.497483		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.209656		73.00
76.00	03020 CARDIAC REHAB	0.937691		76.00
76.01	03021 SLEEP LAB	0.101494		76.01
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.382171		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.864863		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet C
Part II
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,550,054	237,585	1,312,469	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	105,071	9,434	95,637	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,216,298	111,679	2,104,619	0	0	54.00
60.00	06000	LABORATORY	1,501,283	54,630	1,446,653	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	160,187	2,701	157,486	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	619,447	43,806	575,641	0	0	65.00
66.00	06600	PHYSICAL THERAPY	748,205	45,468	702,737	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	296,487	6,013	290,474	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,223,240	37,692	1,185,548	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	214,913	3,732	211,181	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,107,202	24,876	1,082,326	0	0	73.00
76.00	03020	CARDIAC REHAB	151,016	9,874	141,142	0	0	76.00
76.01	03021	SLEEP LAB	73,273	9,090	64,183	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	2,529,773	117,529	2,412,244	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	778,998	0	778,998	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	13,275,447	714,109	12,561,338	0	0	200.00
201.00		Less Observation Beds	778,998	0	778,998	0	0	201.00
202.00		Total (line 200 minus line 201)	12,496,449	714,109	11,782,340	0	0	202.00

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

Provider CCN: 151334

Period: From 01/01/2013 To 12/31/2013

Worksheet C Part II Date/Time Prepared: 6/2/2014 3:43 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1,550,054	5,083,378	0.304926	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	105,071	512,285	0.205103	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,216,298	15,020,723	0.147549	54.00
60.00	06000 LABORATORY	1,501,283	10,770,332	0.139391	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	160,187	144,170	1.111098	63.00
65.00	06500 RESPIRATORY THERAPY	619,447	2,027,154	0.305575	65.00
66.00	06600 PHYSICAL THERAPY	748,205	2,276,561	0.328656	66.00
69.00	06900 ELECTROCARDIOLOGY	296,487	1,369,437	0.216503	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,223,240	2,211,875	0.553033	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	214,913	432,001	0.497483	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,107,202	5,281,047	0.209656	73.00
76.00	03020 CARDIAC REHAB	151,016	161,051	0.937691	76.00
76.01	03021 SLEEP LAB	73,273	721,947	0.101494	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	2,529,773	6,619,478	0.382171	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	778,998	417,724	1.864863	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	13,275,447	53,049,163		200.00
201.00	Less Observation Beds	778,998	0		201.00
202.00	Total (line 200 minus line 201)	12,496,449	53,049,163		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 6/2/2014 3:43 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	237,585	5,083,378	0.046738	155,299	7,258	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9,434	512,285	0.018416	1,022	19	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	111,679	15,020,723	0.007435	697,786	5,188	54.00
60.00	06000 LABORATORY	54,630	10,770,332	0.005072	1,334,534	6,769	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,701	144,170	0.018735	31,079	582	63.00
65.00	06500 RESPIRATORY THERAPY	43,806	2,027,154	0.021610	552,915	11,948	65.00
66.00	06600 PHYSICAL THERAPY	45,468	2,276,561	0.019972	46,450	928	66.00
69.00	06900 ELECTROCARDIOLOGY	6,013	1,369,437	0.004391	289,783	1,272	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	37,692	2,211,875	0.017041	413,188	7,041	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,732	432,001	0.008639	77,423	669	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	24,876	5,281,047	0.004710	1,124,603	5,297	73.00
76.00	03020 CARDIAC REHAB	9,874	161,051	0.061310	0	0	76.00
76.01	03021 SLEEP LAB	9,090	721,947	0.012591	1,576	20	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	117,529	6,619,478	0.017755	358,802	6,371	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	417,724	0.000000	37,828	0	92.00
200.00	Total (Lines 50-199)	714,109	53,049,163		5,122,288	53,362	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet D
Part IV
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description			Title XVIII				Hospital	
			Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Cost
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	0	0	0	0	0	76.01
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: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet D
Part IV
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
			6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	5,083,378	0.000000	0.000000	155,299	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	512,285	0.000000	0.000000	1,022	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,020,723	0.000000	0.000000	697,786	54.00
60.00	06000	LABORATORY	0	10,770,332	0.000000	0.000000	1,334,534	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	144,170	0.000000	0.000000	31,079	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,027,154	0.000000	0.000000	552,915	65.00
66.00	06600	PHYSICAL THERAPY	0	2,276,561	0.000000	0.000000	46,450	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,369,437	0.000000	0.000000	289,783	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,211,875	0.000000	0.000000	413,188	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	432,001	0.000000	0.000000	77,423	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,281,047	0.000000	0.000000	1,124,603	73.00
76.00	03020	CARDIAC REHAB	0	161,051	0.000000	0.000000	0	76.00
76.01	03021	SLEEP LAB	0	721,947	0.000000	0.000000	1,576	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	6,619,478	0.000000	0.000000	358,802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	417,724	0.000000	0.000000	37,828	92.00
200.00		Total (Lines 50-199)	0	53,049,163			5,122,288	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 6/2/2014 3:43 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Cost
		11.00	12.00	13.00	
Title XVIII Hospital					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03020 CARDIAC REHAB	0	0	0	76.00
76.01	03021 SLEEP LAB	0	0	0	76.01
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: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 6/2/2014 3:43 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.304926	0	718,098	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.205103	0	481	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.147549	0	3,758,027	0	0	54.00
60.00	06000 LABORATORY	0.139391	0	2,451,783	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1.111098	0	31,284	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.305575	0	361,276	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.328656	0	735,590	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.216503	0	281,277	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.553033	0	366,504	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.497483	0	72,203	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.209656	0	926,577	0	0	73.00
76.00	03020 CARDIAC REHAB	0.937691	0	94,562	0	0	76.00
76.01	03021 SLEEP LAB	0.101494	0	237,803	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.382171	0	1,219,980	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.864863	0	122,814	0	0	92.00
200.00	Subtotal (see instructions)		0	11,378,259	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	11,378,259	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 6/2/2014 3:43 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	218,967	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	99	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	554,493	0	54.00
60.00	06000 LABORATORY	341,756	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	34,760	0	63.00
65.00	06500 RESPIRATORY THERAPY	110,397	0	65.00
66.00	06600 PHYSICAL THERAPY	241,756	0	66.00
69.00	06900 ELECTROCARDIOLOGY	60,897	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	202,689	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	35,920	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	194,262	0	73.00
76.00	03020 CARDIAC REHAB	88,670	0	76.00
76.01	03021 SLEEP LAB	24,136	0	76.01
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	466,241	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	229,031	0	92.00
200.00	Subtotal (see instructions)	2,804,074	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	2,804,074	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151334 Component CCN: 15Z334	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 6/2/2014 3:43 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.304926	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.205103	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.147549	0	0	0	54.00
60.00	06000 LABORATORY	0.139391	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1.111098	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.305575	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.328656	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.216503	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.553033	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.497483	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.209656	0	0	0	73.00
76.00	03020 CARDIAC REHAB	0.937691	0	0	0	76.00
76.01	03021 SLEEP LAB	0.101494	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0.382171	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.864863	0	0	0	92.00
200.00	Subtotal (see instructions)		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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151334 Component CCN: 15Z334	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 6/2/2014 3:43 pm
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03020 CARDIAC REHAB	0	0	76.00
76.01	03021 SLEEP LAB	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part I Date/Time Prepared: 6/2/2014 3:43 pm
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Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	238,922	4,066	234,856	3,697	63.53	30.00
31.00	INTENSIVE CARE UNIT	16,676		16,676	280	59.56	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
43.00	NURSERY	6,760		6,760	338	20.00	43.00
200.00	Total (lines 30-199)	262,358		258,292	4,315		200.00

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	6.00	7.00	

INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	475	30,177	30.00
31.00	INTENSIVE CARE UNIT	24	1,429	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
43.00	NURSERY	263	5,260	43.00
200.00	Total (lines 30-199)	762	36,866	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 6/2/2014 3:43 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	237,585	5,083,378	0.046738	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9,434	512,285	0.018416	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	111,679	15,020,723	0.007435	0	0	54.00
60.00	06000 LABORATORY	54,630	10,770,332	0.005072	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,701	144,170	0.018735	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	43,806	2,027,154	0.021610	0	0	65.00
66.00	06600 PHYSICAL THERAPY	45,468	2,276,561	0.019972	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	6,013	1,369,437	0.004391	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	37,692	2,211,875	0.017041	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,732	432,001	0.008639	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	24,876	5,281,047	0.004710	0	0	73.00
76.00	03020 CARDIAC REHAB	9,874	161,051	0.061310	0	0	76.00
76.01	03021 SLEEP LAB	9,090	721,947	0.012591	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	117,529	6,619,478	0.017755	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	56,224	417,724	0.134596	0	0	92.00
200.00	Total (lines 50-199)	770,333	53,049,163		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151334		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 6/2/2014 3:43 pm	
Cost Center Description			Title XIX			Hospital		PPS
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,697	0.00	475	0		30.00
31.00	03100	INTENSIVE CARE UNIT	280	0.00	24	0		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0.00	0	0		34.00
43.00	04300	NURSERY	338	0.00	263	0		43.00
200.00		Total (lines 30-199)	4,315		762	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet D
Part IV
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description			Title XIX				Hospital	
			Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	0	0	0	0	0	76.01
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: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 6/2/2014 3:43 pm
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Cost Center Description		Title XIX			Hospital		PPS	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	5,083,378	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	512,285	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,020,723	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	10,770,332	0.000000	0.000000	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	144,170	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,027,154	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,276,561	0.000000	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,369,437	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,211,875	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	432,001	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,281,047	0.000000	0.000000	0	73.00
76.00	03020	CARDIAC REHAB	0	161,051	0.000000	0.000000	0	76.00
76.01	03021	SLEEP LAB	0	721,947	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	6,619,478	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	417,724	0.000000	0.000000	0	92.00
200.00		Total (Lines 50-199)	0	53,049,163			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet D
Part IV
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03020 CARDIAC REHAB	0	0	0		76.00
76.01	03021 SLEEP LAB	0	0	0		76.01
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00	Total (Lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 6/2/2014 3:43 pm
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,812	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,697	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)		2,827	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		64	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		51	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,447	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)		64	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)		3,367,616	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)		57,306	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,310,310	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)		3,310,310	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)		895.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,295,644	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)		1,295,644	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1		
		Title XVIII		Hospital		Date/Time Prepared: 6/2/2014 3:43 pm		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	427,447	280	1,526.60	140	213,724	43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
		1.00						
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						1,328,671	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						2,838,039	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)						57,306	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)						57,306	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/MR ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/MR 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)						870	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						895.40	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						778,998	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 6/2/2014 3:43 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 6/2/2014 3:43 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,812	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,697	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)		2,827	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		64	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		51	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		475	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)		338	15.00
16.00	Nursery days (title V or XIX only)		263	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)		3,367,616	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)		57,306	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,310,310	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)		3,310,310	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)		895.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		425,315	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)		425,315	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 6/2/2014 3:43 pm	
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)	PPS
42.00	NURSERY (title V & XIX only)	237,318	338	702.12	263	184,658	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	427,447	280	1,526.60	24	36,638	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					646,611	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)					36,866	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)					36,866	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					609,745	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/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR 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)					870	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					895.40	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					778,998	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 6/2/2014 3:43 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	238,922	3,310,310	0.072175	778,998	56,224	90.00
91.00	Nursing School cost	0	3,310,310	0.000000	778,998	0	91.00
92.00	Allied health cost	0	3,310,310	0.000000	778,998	0	92.00
93.00	All other Medical Education	0	3,310,310	0.000000	778,998	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 6/2/2014 3:43 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		690,626	30.00
31.00	03100	INTENSIVE CARE UNIT		137,760	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.304926	155,299	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.205103	1,022	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147549	697,786	54.00
60.00	06000	LABORATORY	0.139391	1,334,534	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1.111098	31,079	63.00
65.00	06500	RESPIRATORY THERAPY	0.305575	552,915	65.00
66.00	06600	PHYSICAL THERAPY	0.328656	46,450	66.00
69.00	06900	ELECTROCARDIOLOGY	0.216503	289,783	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.553033	413,188	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.497483	77,423	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.209656	1,124,603	73.00
76.00	03020	CARDIAC REHAB	0.937691	0	76.00
76.01	03021	SLEEP LAB	0.101494	1,576	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.382171	358,802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.864863	37,828	92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,122,288	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)		5,122,288	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15Z334		Date/Time Prepared: 6/2/2014 3:43 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.304926	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.205103	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147549	592	54.00
60.00	06000	LABORATORY	0.139391	4,543	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1.111098	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.305575	3,120	65.00
66.00	06600	PHYSICAL THERAPY	0.328656	31,489	66.00
69.00	06900	ELECTROCARDIOLOGY	0.216503	225	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.553033	1,608	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.497483	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.209656	12,135	73.00
76.00	03020	CARDIAC REHAB	0.937691	0	76.00
76.01	03021	SLEEP LAB	0.101494	0	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.382171	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.864863	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		53,712	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)		53,712	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15Z334		Date/Time Prepared: 6/2/2014 3:43 pm	
		Title XIX	Swing Beds - SNF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.304926	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.205103	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147549	0	54.00
60.00	06000	LABORATORY	0.139391	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1.111098	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.305575	0	65.00
66.00	06600	PHYSICAL THERAPY	0.328656	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.216503	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.553033	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.497483	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.209656	0	73.00
76.00	03020	CARDIAC REHAB	0.937691	0	76.00
76.01	03021	SLEEP LAB	0.101494	0	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.382171	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.864863	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		0	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)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 6/2/2014 3:43 pm
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			2,804,074 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 Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			2,804,074 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 Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			2,832,115 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			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)			31,957 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,787,773 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			1,012,385 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,012,385 30.00
31.00	Primary payer payments			783 31.00
32.00	Subtotal (line 30 minus line 31)			1,011,602 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			707,478 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			622,581 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			259,576 36.00
37.00	Subtotal (see instructions)			1,634,183 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	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)			1,634,183 40.00
40.01	Sequestration adjustment (see instructions)			24,676 40.01
41.00	Interim payments			1,588,306 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			21,201 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 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: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet E-1
Part I
Date/Time Prepared:
6/2/2014 3:43 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,603,892		1,588,306	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,603,892		1,588,306	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		21,201	6.01	
6.02	SETTLEMENT TO PROGRAM		27,421		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,576,471		1,609,507	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: 151334
Component CCN: 15Z334

Period:
From 01/01/2013
To 12/31/2013

Worksheet E-1
Part I
Date/Time Prepared:
6/2/2014 3:43 pm

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		30,200		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)		30,200		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		41,061		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		71,261		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet E-1
Part II
Date/Time Prepared:
6/2/2014 3:43 pm

		Title VIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,023 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,587 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			129 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			3,107 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			55,153,287 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			0 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			834,720 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			627,960 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			627,960 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			627,960 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151334

Period:

Worksheet E-2

Component CCN: 15Z334

From 01/01/2013

Date/Time Prepared:

To 12/31/2013

6/2/2014 3:43 pm

		Title XVIII		Swing Beds - SNF	
		Part A	Part B	Cost	
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	57,879	0	1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00	
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)	15,659	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	64	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)	73,538	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	73,538	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)	73,538	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,184	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)	72,354	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
17.00	Allowable bad debts (see instructions)	0	0	17.00	
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01	
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00	
19.00	Total (see instructions)	72,354	0	19.00	
19.01	Sequestration adjustment (see instructions)	1,093	0	19.01	
20.00	Interim payments	30,200	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	41,061	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet E-2
Component CCN: 15Z334		Date/Time Prepared: 6/2/2014 3:43 pm
Title XIX	Swing Beds - SNF	PPS

		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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)	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	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)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	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)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0		23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151334	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 6/2/2014 3:43 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			2,838,039 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			2,838,039 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,866,419 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 teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (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)			2,866,419 19.00
20.00	Deductibles (exclude professional component)			380,064 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			2,486,355 22.00
23.00	Coinsurance			592 23.00
24.00	Subtotal (line 22 minus line 23)			2,485,763 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			147,965 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			130,209 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			29,262 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,615,972 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			2,615,972 30.00
30.01	Sequestration adjustment (see instructions)			39,501 30.01
31.00	Interim payments			2,603,892 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			-27,421 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

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

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet G

Date/Time Prepared:
6/2/2014 3:43 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,309,783	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,364,879	0	0	0	4.00
5.00	Other receivable	3,205,237	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,337,848	0	0	0	6.00
7.00	Inventory	479,261	0	0	0	7.00
8.00	Prepaid expenses	126,917	0	0	0	8.00
9.00	Other current assets	0	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)	9,148,229	0	0	0	11.00
FIXED ASSETS						
12.00	Land	840,000	0	0	0	12.00
13.00	Land improvements	232,852	0	0	0	13.00
14.00	Accumulated depreciation	-15,690	0	0	0	14.00
15.00	Buildings	2,934,550	0	0	0	15.00
16.00	Accumulated depreciation	-235,627	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	74,359	0	0	0	19.00
20.00	Accumulated depreciation	-4,190	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	895,351	0	0	0	23.00
24.00	Accumulated depreciation	-189,347	0	0	0	24.00
25.00	Minor equipment depreciable	1,498,849	0	0	0	25.00
26.00	Accumulated depreciation	-596,098	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)	5,435,009	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	425,581	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	425,581	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	15,008,819	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	755,790	0	0	0	37.00
38.00	Salaries, wages, and fees payable	818,240	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	213,217	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,787,247	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,417,337	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,417,337	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,204,584	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	11,804,235	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	11,804,235	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	15,008,819	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet G-1

Date/Time Prepared:
6/2/2014 3:43 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		9,165,008		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,137,969			2.00
3.00	Total (sum of line 1 and line 2)		10,302,977		0	3.00
4.00	INCOME TAX	706,390		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		706,390		0	10.00
11.00	Subtotal (line 3 plus line 10)		11,009,367		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		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)		11,009,367		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	INCOME TAX		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
6/2/2014 3:43 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,134,795		2,134,795	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,134,795		2,134,795	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,134,795		2,134,795	17.00
18.00	Ancillary services	10,412,704	43,898,073	54,310,777	18.00
19.00	Outpatient services	0	0	0	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		0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,547,499	43,898,073	56,445,572	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,979,980		29.00
30.00	INCOME TAX	706,390			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)		706,390		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		21,686,370		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151334

Period:
From 01/01/2013
To 12/31/2013

Worksheet G-3

Date/Time Prepared:
6/2/2014 3:43 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	56,445,572	1.00
2.00	Less contractual allowances and discounts on patients' accounts	35,077,697	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,367,875	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,686,370	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-318,495	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	641,292	24.00
24.01	ACCT 591000 - INTEREST INCOME	866	24.01
24.02	ACCT 592901 - EHR	315,755	24.02
24.03	ACCT 592902 - EHR	498,551	24.03
25.00	Total other income (sum of lines 6-24)	1,456,464	25.00
26.00	Total (line 5 plus line 25)	1,137,969	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,137,969	29.00