

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: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet S Parts I-III Date/Time Prepared: 9/24/2013 2:41 pm
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 9/24/2013	Time: 2:41 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 Kindred Hospital Peoria ( 142013 ) for the cost reporting period beginning 05/01/2012 and ending 04/30/2013 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			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	189,498	0	0	-69,836	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
200.00 Total	0	189,498	0	0	-69,836	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: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet S-2 Part I Date/Time Prepared: 9/24/2013 2:37 pm
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1.00 Hospital and Hospital Health Care Complex Address:	2.00 Street: 500 West Romeo B Garrett Ave.	PO Box:	3.00 State: IL	4.00 Zip Code: 61605	County: Peoria	1.00	2.00
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Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
					V	XVIII	XIX
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00

Hospital and Hospital-Based Component Identification:									
3.00 Hospital	Kindred Hospital Peoria	142013	37900	2	05/01/2010	N	P	O	3.00
4.00 Subprovider - IPF									4.00
5.00 Subprovider - IRF									5.00
6.00 Subprovider - (Other)									6.00
7.00 Swing Beds - SNF									7.00
8.00 Swing Beds - NF									8.00
9.00 Hospital-Based SNF									9.00
10.00 Hospital-Based NF									10.00
11.00 Hospital-Based OLTC									11.00
12.00 Hospital-Based HHA									12.00
13.00 Separately Certified ASC									13.00
14.00 Hospital-Based Hospice									14.00
15.00 Hospital-Based Health Clinic - RHC									15.00
16.00 Hospital-Based Health Clinic - FQHC									16.00
17.00 Hospital-Based (CMHC) I									17.00
18.00 Renal Dialysis									18.00
19.00 Other									19.00

		From:	To:	
20.00 Cost Reporting Period (mm/dd/yyyy)		1.00 05/01/2012	2.00 04/30/2013	20.00
21.00 Type of Control (see instructions)		4		21.00

Inpatient PPS Information				
22.00 Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.		N	N	22.00
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.		2	N	23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in 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							24.00
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							25.00

		Urban/Rural	S	Date of Geogr	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		1			26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		1			27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0			35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet S-2 Part I Date/Time Prepared: 9/24/2013 2:37 pm		
		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 the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	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
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete 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.					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 Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00		0.00	61.00
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
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 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet S-2  
Part I  
Date/Time Prepared:  
9/24/2013 2:37 pm

	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	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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

	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	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.		0.00	0.00	0.000000	67.00

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		1.00	2.00	3.00		
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have 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 subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have 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 subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		76.00
				1.00		
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			Y		80.00
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
		V	XIX			
		1.00	2.00			
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			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		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				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)					106.00
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)					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00	2.00	3.00
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If 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.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	13,161	2,529	113,149	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
<b>All Providers</b>					
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	189003	140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: KINDRED HEALTHCARE INC	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		Contractor's Number: 05901	141.00
142.00	Street: 680 SOUTH FOURTH AVENUE	PO Box:			142.00
143.00	City: LOUISVILLE	State: KY	Zip Code: 40202		143.00
			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.		Y		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	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142013		Period: From 05/01/2012 To 04/30/2013		Worksheet S-2 Part I Date/Time Prepared: 9/24/2013 2:37 pm		
							1.00	
<b>Multi campus</b>								
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						0.00	166.00
166.01							0.00	166.01
166.02							0.00	166.02
166.03							0.00	166.03
							1.00	
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet S-2 Part II Date/Time Prepared: 9/24/2013 2:37 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/31/2014	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.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	08/31/2013	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

	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					
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	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
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2013	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
1.00					2.00
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN		HOURIGAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	KINDRED HEALTHCARE INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5025967856		Daniel.Hourigan@kindred.com	43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	08/31/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/24/2013 2:37 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)	30.00	50	18,250	0.00	0	1.00
2.00 HMO						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)		50	18,250	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		50	18,250	0.00	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	44.00	0	0		0	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
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)		50				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)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/24/2013 2:37 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)	6,807	60	8,696			1.00
2.00 HMO	418	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	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,807	60	8,696			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	6,807	60	8,696	0.00	99.50	14.00
15.00 CAH visits	0	0	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	0	0	0	0.00	0.00	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
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	99.50	27.00
28.00 Observation Bed Days		0	0			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			32.00
33.00 LTCH non-covered days	14					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/24/2013 2:37 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)			0	264	1	330	1.00
2.00 HMO				15			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	264	1	330	14.00	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	0.00						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
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
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 142013		Period: From 05/01/2012 To 04/30/2013		Worksheet S-3 Part II Date/Time Prepared: 9/24/2013 2:37 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	5,903,763	0	5,903,763	206,921.00	28.53	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	94,771	94,771	2,495.00	37.98	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor (see instructions)		803,068	0	803,068	14,512.00	55.34	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		24,566	0	24,566	171.00	143.66	13.00
14.00	Home office salaries & wage-related costs		638,089	0	638,089	13,366.00	47.74	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		1,147,568	0	1,147,568			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		18,722	0	18,722			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits	4.00	87,019	0	87,019	4,267.00	20.39	26.00
27.00	Administrative & General	5.00	1,039,336	0	1,039,336	26,597.00	39.08	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	22,267	0	22,267	1,066.00	20.89	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	107,933	0	107,933	8,085.00	13.35	32.00
33.00	Housekeeping under contract (see instructions)		11,062	0	11,062	700.00	15.80	33.00
34.00	Dietary	10.00	125,001	0	125,001	8,360.00	14.95	34.00
35.00	Dietary under contract (see instructions)		39,094	0	39,094	2,052.00	19.05	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	653,920	0	653,920	19,520.00	33.50	38.00
39.00	Central Services and Supply	14.00	62,620	0	62,620	3,410.00	18.36	39.00
40.00	Pharmacy	15.00	357,577	0	357,577	8,629.00	41.44	40.00
41.00	Medical Records & Medical Records Library	16.00	268,903	0	268,903	9,183.00	29.28	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet S-3  
Part II  
Date/Time Prepared:  
9/24/2013 2:37 pm

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Soci al Servi ce	17.00	398,526	-94,771	303,755	7,997.00	37.98	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet S-3  
Part III  
Date/Time Prepared:  
9/24/2013 2:37 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	5,953,919	0	5,953,919	209,673.00	28.40	1.00
2.00	Excluded area salaries (see instructions)	0	94,771	94,771	2,495.00	37.98	2.00
3.00	Subtotal salaries (line 1 minus line 2)	5,953,919	-94,771	5,859,148	207,178.00	28.28	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,465,723	0	1,465,723	28,049.00	52.26	4.00
5.00	Subtotal wage-related costs (see inst.)	1,147,568	0	1,147,568	0.00	19.59	5.00
6.00	Total (sum of lines 3 thru 5)	8,567,210	-94,771	8,472,439	235,227.00	36.02	6.00
7.00	Total overhead cost (see instructions)	3,173,258	-94,771	3,078,487	99,866.00	30.83	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet S-3 Part IV Date/Time Prepared: 9/24/2013 2:37 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			-293 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)			481,383 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			4,545 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			4,031 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			21,793 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			129,364 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			405,717 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			84,692 20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			16,335 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			1,147,567 24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet S-7

Date/Time Prepared:  
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		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N			2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	0	0	0 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	0	0 19.00
20.00		RHA	0	0	0 20.00
21.00		RMC	0	0	0 21.00
22.00		RMB	0	0	0 22.00
23.00		RMA	0	0	0 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	0	0 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	0	0 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	0	0 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet S-7

Date/Time Prepared:  
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		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).					201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet A  
Date/Time Prepared:  
9/24/2013 2:37 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		2,082,617	2,082,617	35,599	2,118,216	1.00
2.00	00200		1,094,029	1,094,029	326,867	1,420,896	2.00
3.00	00300		362,466	362,466	-362,466	0	3.00
4.00	00400	87,019	1,265,256	1,352,275	0	1,352,275	4.00
5.00	00500	1,039,336	1,327,810	2,367,146	-735	2,366,411	5.00
7.00	00700	22,267	575,337	597,604	0	597,604	7.00
8.00	00800	0	58,827	58,827	0	58,827	8.00
9.00	00900	107,933	96,885	204,818	0	204,818	9.00
10.00	01000	125,001	351,293	476,294	0	476,294	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	653,920	8,451	662,371	0	662,371	13.00
14.00	01400	62,620	12,467	75,087	0	75,087	14.00
15.00	01500	357,577	14,845	372,422	0	372,422	15.00
16.00	01600	268,903	95,440	364,343	0	364,343	16.00
17.00	01700	398,526	46,626	445,152	-105,859	339,293	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,082,326	1,122,855	3,205,181	6,435	3,211,616	30.00
31.00	03100	0	6,300	6,300	-6,300	0	31.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	226,410	226,410	0	226,410	50.00
54.00	05400	164,914	62,005	226,919	0	226,919	54.00
60.00	06000	0	321,522	321,522	0	321,522	60.00
65.00	06500	533,421	28,165	561,586	600	562,186	65.00
66.00	06600	0	359,679	359,679	0	359,679	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	620,008	620,008	0	620,008	71.00
73.00	07300	0	663,345	663,345	0	663,345	73.00
74.00	07400	0	146,744	146,744	0	146,744	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	05950	0	0	0	0	0	98.00
100.00	10000	0	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		5,903,763	10,949,382	16,853,145	-105,859	16,747,286	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	105,859	105,859	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00		5,903,763	10,949,382	16,853,145	0	16,853,145	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet A  
Date/Time Prepared:  
9/24/2013 2:37 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-37,222	2,080,994	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-81,701	1,339,195	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	0	1,352,275	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	824,363	3,190,774	5.00
7.00	00700	OPERATION OF PLANT	-527	597,077	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	58,827	8.00
9.00	00900	HOUSEKEEPING	0	204,818	9.00
10.00	01000	DIETARY	-29,016	447,278	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	662,371	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	75,087	14.00
15.00	01500	PHARMACY	0	372,422	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-753	363,590	16.00
17.00	01700	SOCIAL SERVICE	0	339,293	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-257,300	2,954,316	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	226,410	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	226,919	54.00
60.00	06000	LABORATORY	0	321,522	60.00
65.00	06500	RESPIRATORY THERAPY	0	562,186	65.00
66.00	06600	PHYSICAL THERAPY	0	359,679	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	620,008	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	663,345	73.00
74.00	07400	RENAL DIALYSIS	0	146,744	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	417,844	17,165,130	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	105,859	194.00
194.01	07951	IDLE SPACE	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	194.11
200.00		TOTAL (SUM OF LINES 118-199)	417,844	17,270,989	200.00

RECLASSIFICATIONS

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet A-6

Date/Time Prepared:  
9/24/2013 2:37 pm

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
<b>A - RECLASS NON ALLOWABLE CASE MANAGER</b>						
1.00	NONALLOWABLE CASE MANAGER		194.00	94,771	11,088	1.00
	TOTALS			94,771	11,088	
<b>C - RECLASS ICU EXPENSE</b>						
1.00	ADULTS & PEDIATRICS		30.00	0	6,300	1.00
	TOTALS			0	6,300	
<b>F - RECLASS PY RT NURSING CNTRCT ACCRUAL</b>						
1.00	RESPIRATORY THERAPY		65.00	0	600	1.00
	TOTALS			0	600	
<b>G - RECLASS NURSE CONTRACT TO A&amp;P</b>						
1.00	ADULTS & PEDIATRICS		30.00	0	735	1.00
	TOTALS			0	735	
500.00	Grand Total: Increases			94,771	18,723	500.00

RECLASSIFICATIONS

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

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 - RECLASS NON ALLOWABLE CASE MANAGER								
1.00		SOCIAL SERVICE	17.00	94,771	11,088		0	1.00
		TOTALS		94,771	11,088			
C - RECLASS ICU EXPENSE								
1.00		INTENSIVE CARE UNIT	31.00	0	6,300		0	1.00
		TOTALS		0	6,300			
F - RECLASS PY RT NURSING CNTRCT ACCRUAL								
1.00		ADULTS & PEDIATRICS	30.00	0	600		0	1.00
		TOTALS		0	600			
G - RECLASS NURSE CONTRACT TO A&P								
1.00		ADMINISTRATIVE & GENERAL	5.00	0	735		0	1.00
		TOTALS		0	735			
500.00		Grand Total: Decreases		94,771	18,723			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet A-7  
Part I  
Date/Time Prepared:  
9/24/2013 2:37 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	257,293	65,187	0	65,187	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	2,807,404	153,587	0	153,587	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	3,064,697	218,774	0	218,774	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	3,064,697	218,774	0	218,774	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	322,480	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	2,960,991	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	3,283,471	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	3,283,471	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet A-7  
Part II  
Date/Time Prepared:  
9/24/2013 2:37 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	62,031	2,020,586	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	701,854	392,175	0	0	0	2.00
3.00	Total (sum of lines 1-2)	763,885	2,412,761	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	2,082,617				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,094,029				2.00
3.00	Total (sum of lines 1-2)	0	3,176,646				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet A-7  
Part III  
Date/Time Prepared:  
9/24/2013 2:37 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	322,480	0	322,480	0.098213	2,658	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,960,991	0	2,960,991	0.901787	24,409	2.00
3.00	Total (sum of lines 1-2)	3,283,471	0	3,283,471	1.000000	27,067	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	32,941	0	35,599	29,546	2,020,586	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	302,458	0	326,867	620,153	392,175	2.00
3.00	Total (sum of lines 1-2)	335,399	0	362,466	649,699	2,412,761	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	-2,079	32,941	0	2,080,994	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	24,409	302,458	0	1,339,195	2.00
3.00	Total (sum of lines 1-2)	0	22,330	335,399	0	3,420,189	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet A-8

Date/Time Prepared:  
9/24/2013 2:37 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.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)	B	-208		ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-677		ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-7,857		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-527		OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)		0			0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-257,135				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,265,971				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-16,671		DIETARY	10.00	0	14.00
15.00 Rental of quarters to employee and others		0			0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00 Sale of drugs to other than patients		0			0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-918		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	-12,345		DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0		CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0		CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0		*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0			0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0		OCCUPATIONAL THERAPY	67.00		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0		SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 CONTRIBUTIONS AND DONATIONS	B	-295		ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01 MISCELLANEOUS INCOME	B	-481,947		ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02		0			0.00	0	33.02
33.03		0			0.00	0	33.03

ADJUSTMENTS TO EXPENSES

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet A-8

Date/Time Prepared:  
9/24/2013 2:37 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		4.00
33.04		0			0.00	0	33.04
33.05		0			0.00	0	33.05
33.06		0			0.00	0	33.06
33.07		0			0.00	0	33.07
33.08	MEDICARE BAD DEBT - PART A	-285,993	ADMINISTRATIVE & GENERAL		5.00	0	33.08
33.09		0			0.00	0	33.09
33.10	OTHER MEDICARE NON ALLOWABLE	-1,200	ADMINISTRATIVE & GENERAL		5.00	0	33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	-324	ADMINISTRATIVE & GENERAL		5.00	0	33.11
33.12		0			0.00	0	33.12
33.13	OTHER OPERATING - MARKETING	-9,678	ADMINISTRATIVE & GENERAL		5.00	0	33.13
33.14		0			0.00	0	33.14
33.15		0			0.00	0	33.15
33.16		0			0.00	0	33.16
33.17		0			0.00	0	33.17
33.18		0			0.00	0	33.18
33.19		0			0.00	0	33.19
33.20	OTHER OPERATING - TRADE SHOW BOOTH	-641	ADMINISTRATIVE & GENERAL		5.00	0	33.20
33.21		0			0.00	0	33.21
33.22		0			0.00	0	33.22
33.23	CHARITABLE CONTRIBUTIONS	-1,300	ADMINISTRATIVE & GENERAL		5.00	0	33.23
33.24		0			0.00	0	33.24
33.25		0			0.00	0	33.25
33.26		0			0.00	0	33.26
33.27		0			0.00	0	33.27
33.28	AGGREGATE CAPITAL EROSION	-7,810	ADMINISTRATIVE & GENERAL		5.00	0	33.28
33.29	CABLE TV AND SATELLITE	-3,603	ADMINISTRATIVE & GENERAL		5.00	0	33.29
33.30		0			0.00	0	33.30
33.31		0			0.00	0	33.31
33.32	RENT - OTHER	-12	ADMINISTRATIVE & GENERAL		5.00	0	33.32
33.33		0			0.00	0	33.33
33.34	MALPRACTICE TAIL LIABILITY	18,633	ADMINISTRATIVE & GENERAL		5.00	0	33.34
33.35	AGGREGATE CAP PYMT-NONALLOWABLE	2,529	ADMINISTRATIVE & GENERAL		5.00	0	33.35
33.36		0			0.00	0	33.36
33.37	PHYSICIAN BILLING COLLECTION FEES	-18,991	ADMINISTRATIVE & GENERAL		5.00	0	33.37
33.38		0			0.00	0	33.38
33.39		0			0.00	0	33.39
33.40		0			0.00	0	33.40
34.00	MEDICARE VS BOOK BLDG	-32,485	CAP REL COSTS-BLDG & FIXT		1.00	9	34.00
34.01	MEDICARE VS BOOK MOV EQUIP	-100,927	CAP REL COSTS-MVBLE EQUIP		2.00	9	34.01
34.02		0			0.00	0	34.02
34.03	ASSET ADD-ON MOV EQUIP	22,732	CAP REL COSTS-MVBLE EQUIP		2.00	9	34.03
34.04	MSA MGMT FEE REV ADD-BACK	470,889	ADMINISTRATIVE & GENERAL		5.00	0	34.04
34.05	MSA MGMT FEE EXP OFFSET	-470,889	ADMINISTRATIVE & GENERAL		5.00	0	34.05
34.06	NON ALLOWABLE LOBBYING FEES	-4,512	ADMINISTRATIVE & GENERAL		5.00	0	34.06
34.07	OTHER NONALLOW DUES & SUBSCRIPTIONS	-897	ADMINISTRATIVE & GENERAL		5.00	0	34.07
34.08	BUSINESS INTERRUPTION INS PREMIUM	-4,737	CAP REL COSTS-BLDG & FIXT		1.00	12	34.08
34.09		0			0.00	0	34.09
34.10		0			0.00	0	34.10
34.11		0			0.00	0	34.11
34.12		0			0.00	0	34.12
34.13		0			0.00	0	34.13
34.14	PATIENT PHONE - DEPREC EQUIP	-3,506	CAP REL COSTS-MVBLE EQUIP		2.00	9	34.14
34.15	DEFERRED PRE OPENING COSTS	363,175	ADMINISTRATIVE & GENERAL		5.00	0	34.15
34.16		0			0.00	0	34.16
34.17		0			0.00	0	34.17
34.18		0			0.00	0	34.18
34.19		0			0.00	0	34.19
34.20		0			0.00	0	34.20
34.21		0			0.00	0	34.21
34.22		0			0.00	0	34.22
34.23		0			0.00	0	34.23
34.24		0			0.00	0	34.24
35.00		0			0.00	0	35.00

Provider CCN: 142013

Period:  
 From 05/01/2012  
 To 04/30/2013

Worksheet A-8

Date/Time Prepared:  
 9/24/2013 2:37 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	4.00
35.01		0			0.00	0	35.01
35.02		0			0.00	0	35.02
35.03		0			0.00	0	35.03
35.04		0			0.00	0	35.04
35.05		0			0.00	0	35.05
35.06		0			0.00	0	35.06
35.07		0			0.00	0	35.07
35.08		0			0.00	0	35.08
35.09	PHYSICIAN FEE ADJUSTMENT	A	230	MEDICAL RECORDS & LIBRARY	16.00	0	35.09
35.10			0		0.00	0	35.10
35.11	PHYSICIAN FEE ADJUSTMENT	A	-230	ADULTS & PEDIATRICS	30.00	0	35.11
35.12			0		0.00	0	35.12
35.13			0		0.00	0	35.13
35.14			0		0.00	0	35.14
35.15			0		0.00	0	35.15
35.16			0		0.00	0	35.16
35.17			0		0.00	0	35.17
35.18			0		0.00	0	35.18
35.19			0		0.00	0	35.19
35.20			0		0.00	0	35.20
35.21			0		0.00	0	35.21
35.22			0		0.00	0	35.22
35.23			0		0.00	0	35.23
35.24			0		0.00	0	35.24
35.25			0		0.00	0	35.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		417,844				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS  
 Provider CCN: 142013  
 Period: From 05/01/2012 To 04/30/2013  
 Worksheet A-8-1  
 Date/Time Prepared: 9/24/2013 2:37 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		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR HOME OFFICE COSTS:</b>						
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	980,755	-285,216	1.00
2.00	4.00	EMPLOYEE BENEFITS	Workers Comp Premium	122,857	122,857	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	121,292	121,292	3.00
4.00	0.00			0	0	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
5.00	0			1,224,904	-41,067	5.00

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

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

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

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

6.00	B	Kindred Inc-Hos	100.00	Admin & Gen	100.00	6.00
7.00	B	Kindred Inc-Hos	100.00	Cornerstone	100.00	7.00
8.00	B	Kindred Inc-Hos	100.00	Cornerstone	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
10.01			0.00		0.00	10.01
10.02			0.00		0.00	10.02
10.03			0.00		0.00	10.03
10.04			0.00		0.00	10.04
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: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet A-8-1

Date/Time Prepared:  
9/24/2013 2:37 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	1,265,971	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
5.00	1,265,971			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>		

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

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

6.00	HomeOffice Cost		6.00
7.00	Worker Comp Ins		7.00
8.00	Liability Insur		8.00
9.00			9.00
10.00			10.00
10.01			10.01
10.02			10.02
10.03			10.03
10.04			10.04
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: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet A-8-2

Date/Time Prepared:  
9/24/2013 2:37 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	DR. A	19,140	0	19,140	171,400	133	1.00
2.00	30.00	DR. B	5,196	0	5,196	171,400	36	2.00
3.00	30.00	DR. C	94,166	94,166	0	171,400	0	3.00
4.00	30.00	DR. D	53,095	53,095	0	171,400	0	4.00
5.00	30.00	DR. E	89,012	89,012	0	171,400	0	5.00
6.00	30.00	DR. F	10,388	10,388	0	171,400	0	6.00
7.00	16.00	DR. G	230	0	230	171,400	2	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			271,227	246,661	24,566		171	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	DR. A	10,960	548	0	0	0	1.00
2.00	30.00	DR. B	2,967	148	0	0	0	2.00
3.00	30.00	DR. C	0	0	0	0	0	3.00
4.00	30.00	DR. D	0	0	0	0	0	4.00
5.00	30.00	DR. E	0	0	0	0	0	5.00
6.00	30.00	DR. F	0	0	0	0	0	6.00
7.00	16.00	DR. G	165	8	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			14,092	704	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	DR. A	0	10,960	8,180	8,180	1.00
2.00	30.00	DR. B	0	2,967	2,229	2,229	2.00
3.00	30.00	DR. C	0	0	0	94,166	3.00
4.00	30.00	DR. D	0	0	0	53,095	4.00
5.00	30.00	DR. E	0	0	0	89,012	5.00
6.00	30.00	DR. F	0	0	0	10,388	6.00
7.00	16.00	DR. G	0	165	65	65	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	14,092	10,474	257,135	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet B  
Part I  
Date/Time Prepared:  
9/24/2013 2:37 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,080,994	2,080,994			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,339,195		1,339,195		2.00
4.00 00400	EMPLOYEE BENEFITS	1,352,275	10,637	6,918	1,369,830	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,190,774	85,094	55,340	244,762	3,575,970
7.00 00700	OPERATION OF PLANT	597,077	240,065	156,125	5,244	998,511
8.00 00800	LAUNDRY & LINEN SERVICE	58,827	0	0	0	58,827
9.00 00900	HOUSEKEEPING	204,818	32,944	21,425	25,418	284,605
10.00 01000	DIETARY	447,278	119,959	78,015	29,437	674,689
11.00 01100	CAFETERIA	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	662,371	18,023	11,721	153,997	846,112
14.00 01400	CENTRAL SERVICES & SUPPLY	75,087	55,400	36,029	14,747	181,263
15.00 01500	PHARMACY	372,422	29,362	19,095	84,209	505,088
16.00 01600	MEDICAL RECORDS & LIBRARY	363,590	30,100	19,576	63,326	476,592
17.00 01700	SOCIAL SERVICE	339,293	0	0	71,534	410,827
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	2,954,316	992,575	645,519	490,381	5,082,791
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	226,410	0	0	0	226,410
54.00 05400	RADIOLOGY-DIAGNOSTIC	226,919	36,416	23,683	38,837	325,855
60.00 06000	LABORATORY	321,522	9,012	5,861	0	336,395
65.00 06500	RESPIRATORY THERAPY	562,186	17,913	11,649	125,620	717,368
66.00 06600	PHYSICAL THERAPY	359,679	381,703	248,239	0	989,621
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	620,008	0	0	0	620,008
73.00 07300	DRUGS CHARGED TO PATIENTS	663,345	0	0	0	663,345
74.00 07400	RENAL DIALYSIS	146,744	0	0	0	146,744
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
100.00 10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	17,165,130	2,059,203	1,339,195	1,347,512	17,121,021
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	NONALLOWABLE CASE MANAGER	105,859	21,791	0	22,318	149,968
194.01 07951	IDLE SPACE	0	0	0	0	0
194.02 07952	REGIONAL OFFICE	0	0	0	0	0
194.03 07953	DISTRICT OFFICE	0	0	0	0	0
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05 07955	REG NURSG OFFICE	0	0	0	0	0
194.06 07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0
194.07 07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09 07958	VISITOR MEALS	0	0	0	0	0
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	17,270,989	2,080,994	1,339,195	1,369,830	17,270,989

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,575,970				5.00
7.00	00700	OPERATION OF PLANT	260,726	1,259,237			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,361	0	74,188		8.00
9.00	00900	HOUSEKEEPING	74,315	24,071	0	382,991	9.00
10.00	01000	DIETARY	176,171	87,650	0	27,178	965,688
11.00	01100	CAFETERIA	0	0	0	467,873	11.00
13.00	01300	NURSING ADMINISTRATION	220,933	13,169	0	4,083	0
14.00	01400	CENTRAL SERVICES & SUPPLY	47,330	40,479	0	12,551	0
15.00	01500	PHARMACY	131,886	21,454	0	6,652	0
16.00	01600	MEDICAL RECORDS & LIBRARY	124,445	21,993	0	6,820	0
17.00	01700	SOCIAL SERVICE	107,273	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,327,188	725,242	74,188	224,878	494,407
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	59,119	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,086	26,608	0	8,250	0
60.00	06000	LABORATORY	87,838	6,585	0	2,042	0
65.00	06500	RESPIRATORY THERAPY	187,316	13,088	0	4,058	0
66.00	06600	PHYSICAL THERAPY	258,405	278,898	0	86,479	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	161,893	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	173,209	0	0	0	0
74.00	07400	RENAL DIALYSIS	38,317	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,536,811	1,259,237	74,188	382,991	962,280
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	39,159	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0	0
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09	07958	VISITOR MEALS	0	0	0	0	3,408
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,575,970	1,259,237	74,188	382,991	965,688

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	467,873					11.00
13.00	01300	57,717	1,142,014				13.00
14.00	01400	9,824	0	291,447			14.00
15.00	01500	25,174	0	1,605	691,859		15.00
16.00	01600	27,016	0	0	0	656,866	16.00
17.00	01700	30,700	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	244,375	1,142,014	16,946	5,115	238,683	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	0	8,946	50.00
54.00	05400	12,894	0	324	0	17,426	54.00
60.00	06000	0	0	52	0	40,718	60.00
65.00	06500	60,173	0	6,737	0	115,144	65.00
66.00	06600	0	0	27	0	27,026	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	265,756	0	74,127	71.00
73.00	07300	0	0	0	686,744	124,674	73.00
74.00	07400	0	0	0	0	10,122	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	05950	0	0	0	0	0	98.00
100.00	10000	0	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		467,873	1,142,014	291,447	691,859	656,866	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		467,873	1,142,014	291,447	691,859	656,866	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400					14.00
15.00	01500					15.00
16.00	01600					16.00
17.00	01700	548,800				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	548,800	10,124,627	0	10,124,627	30.00
31.00	03100	0	0	0	0	31.00
44.00	04400	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	0	294,475	0	294,475	50.00
54.00	05400	0	476,443	0	476,443	54.00
60.00	06000	0	473,630	0	473,630	60.00
65.00	06500	0	1,103,884	0	1,103,884	65.00
66.00	06600	0	1,640,456	0	1,640,456	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
71.00	07100	0	1,121,784	0	1,121,784	71.00
73.00	07300	0	1,647,972	0	1,647,972	73.00
74.00	07400	0	195,183	0	195,183	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	0	0	0	0	90.00
91.00	09100	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	0	0	0	0	95.00
98.00	09500	0	0	0	0	98.00
100.00	10000	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		548,800	17,078,454	0	17,078,454	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
194.00	07950	0	189,127	0	189,127	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
194.03	07953	0	0	0	0	194.03
194.04	07954	0	0	0	0	194.04
194.05	07955	0	0	0	0	194.05
194.06	07956	0	0	0	0	194.06
194.07	07957	0	0	0	0	194.07
194.08	07959	0	0	0	0	194.08
194.09	07958	0	3,408	0	3,408	194.09
194.10	07962	0	0	0	0	194.10
194.11	07961	0	0	0	0	194.11
200.00		0	0	0	0	200.00
201.00		0	0	0	0	201.00
202.00		548,800	17,270,989	0	17,270,989	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet B Part II Date/Time Prepared: 9/24/2013 2:37 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	10,637	6,918	17,555	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	115,257	85,094	55,340	255,691	5.00
7.00 00700	OPERATION OF PLANT	0	240,065	156,125	396,190	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	32,944	21,425	54,369	9.00
10.00 01000	DIETARY	0	119,959	78,015	197,974	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	18,023	11,721	29,744	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	55,400	36,029	91,429	14.00
15.00 01500	PHARMACY	0	29,362	19,095	48,457	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	30,100	19,576	49,676	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	992,575	645,519	1,638,094	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	36,416	23,683	60,099	54.00
60.00 06000	LABORATORY	0	9,012	5,861	14,873	60.00
65.00 06500	RESPIRATORY THERAPY	0	17,913	11,649	29,562	65.00
66.00 06600	PHYSICAL THERAPY	0	381,703	248,239	629,942	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09500	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
100.00 10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	115,257	2,059,203	1,339,195	3,513,655	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CASE MANAGER	0	21,791	0	21,791	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07 07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
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)	115,257	2,080,994	1,339,195	3,535,446	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet B Part II Date/Time Prepared: 9/24/2013 2:37 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	258,828				5.00	
7.00	00700	OPERATION OF PLANT	18,871	415,128			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	1,112	0	1,112		8.00	
9.00	00900	HOUSEKEEPING	5,379	7,935	0	68,009	9.00	
10.00	01000	DIETARY	12,751	28,895	0	4,826	244,823	10.00
11.00	01100	CAFETERIA	0	0	0	0	118,616	11.00
13.00	01300	NURSING ADMINISTRATION	15,991	4,341	0	725	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,426	13,344	0	2,229	0	14.00
15.00	01500	PHARMACY	9,546	7,073	0	1,181	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,007	7,250	0	1,211	0	16.00
17.00	01700	SOCIAL SERVICE	7,764	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	96,063	239,089	1,112	39,932	125,343	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,279	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,158	8,772	0	1,465	0	54.00
60.00	06000	LABORATORY	6,358	2,171	0	363	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,558	4,315	0	721	0	65.00
66.00	06600	PHYSICAL THERAPY	18,703	91,943	0	15,356	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,718	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,537	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,773	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	255,994	415,128	1,112	68,009	243,959	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	2,834	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	864	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
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)	258,828	415,128	1,112	68,009	244,823	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142013		Period: From 05/01/2012 To 04/30/2013		Worksheet B Part II Date/Time Prepared: 9/24/2013 2:37 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	118,616					11.00
13.00	01300	14,632	67,407				13.00
14.00	01400	2,491	0	113,108			14.00
15.00	01500	6,382	0	623	74,341		15.00
16.00	01600	6,849	0	0	0	74,805	16.00
17.00	01700	7,783	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	61,955	67,407	6,577	550	27,185	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	0	1,019	50.00
54.00	05400	3,269	0	126	0	1,984	54.00
60.00	06000	0	0	20	0	4,637	60.00
65.00	06500	15,255	0	2,615	0	13,112	65.00
66.00	06600	0	0	11	0	3,077	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	103,136	0	8,441	71.00
73.00	07300	0	0	0	73,791	14,197	73.00
74.00	07400	0	0	0	0	1,153	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	05950	0	0	0	0	0	98.00
100.00	10000	0	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		118,616	67,407	113,108	74,341	74,805	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		118,616	67,407	113,108	74,341	74,805	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet B Part II Date/Time Prepared: 9/24/2013 2:37 pm
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE	16,464			17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	16,464	2,326,054	0	2,326,054	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	5,298	0	5,298	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	82,371	0	82,371	54.00
60.00	06000	LABORATORY	0	28,422	0	28,422	60.00
65.00	06500	RESPIRATORY THERAPY	0	80,748	0	80,748	65.00
66.00	06600	PHYSICAL THERAPY	0	759,032	0	759,032	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	123,295	0	123,295	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100,525	0	100,525	73.00
74.00	07400	RENAL DIALYSIS	0	3,926	0	3,926	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09800	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,464	3,509,671	0	3,509,671	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	24,911	0	24,911	194.00
194.01	07951	IDLE SPACE	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	864	0	864	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	16,464	3,535,446	0	3,535,446	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet B-1  
Date/Time Prepared:  
9/24/2013 2:37 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	56,345				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		55,755			2.00
4.00 00400	EMPLOYEE BENEFITS	288	288	5,816,744		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,304	2,304	1,039,336	-3,575,970	5.00
7.00 00700	OPERATION OF PLANT	6,500	6,500	22,267	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	892	892	107,933	0	9.00
10.00 01000	DIETARY	3,248	3,248	125,001	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	488	488	653,920	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,500	1,500	62,620	0	14.00
15.00 01500	PHARMACY	795	795	357,577	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	815	815	268,903	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	303,755	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	26,875	26,875	2,082,326	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	986	986	164,914	0	54.00
60.00 06000	LABORATORY	244	244	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	485	485	533,421	0	65.00
66.00 06600	PHYSICAL THERAPY	10,335	10,335	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09800	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
100.00 10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	55,755	55,755	5,721,973	-3,575,970	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CASE MANAGER	590	0	94,771	0	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07 07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,080,994	1,339,195	1,369,830	3,575,970	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	36.933073	24.019281	0.235498	0.261115	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			17,555	258,828	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.003018	0.018899	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	46,663				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,696			8.00
9.00	00900	HOUSEKEEPING	892	0	45,771		9.00
10.00	01000	DIETARY	3,248	0	3,248	23,802	10.00
11.00	01100	CAFETERIA	0	0	0	11,532	762 11.00
13.00	01300	NURSING ADMINISTRATION	488	0	488	0	94 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,500	0	1,500	0	16 14.00
15.00	01500	PHARMACY	795	0	795	0	41 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	815	0	815	0	44 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	50 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	26,875	8,696	26,875	12,186	398 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	986	0	986	0	21 54.00
60.00	06000	LABORATORY	244	0	244	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	485	0	485	0	98 65.00
66.00	06600	PHYSICAL THERAPY	10,335	0	10,335	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
98.00	09800	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0 100.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	46,663	8,696	45,771	23,718	762 118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0 194.00
194.01	07951	IDLE SPACE	0	0	0	0	0 194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0 194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0 194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0 194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0 194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0 194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0 194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0 194.08
194.09	07958	VISITOR MEALS	0	0	0	84	0 194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0 194.11
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)	1,259,237	74,188	382,991	965,688	467,873 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.985770	8.531279	8.367547	40.571717	614.006562 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	415,128	1,112	68,009	244,823	118,616 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.896299	0.127875	1.485853	10.285816	155.664042 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet B-1

Date/Time Prepared:  
9/24/2013 2:37 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	398					13.00
14.00	01400	0	679,946				14.00
15.00	01500	0	3,745	668,286			15.00
16.00	01600	0	0	0	48,446,149		16.00
17.00	01700	0	0	0	0	8,696	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	398	39,536	4,941	17,604,440	8,696	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	659,781	0	50.00
54.00	05400	0	755	0	1,285,217	0	54.00
60.00	06000	0	121	0	3,003,033	0	60.00
65.00	06500	0	15,717	0	8,492,054	0	65.00
66.00	06600	0	64	0	1,993,185	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	620,008	0	5,466,964	0	71.00
73.00	07300	0	0	663,345	9,194,948	0	73.00
74.00	07400	0	0	0	746,527	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	09800	0	0	0	0	0	98.00
100.00	10000	0	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		398	679,946	668,286	48,446,149	8,696	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00							201.00
202.00		1,142,014	291,447	691,859	656,866	548,800	202.00
203.00		2,869.381910	0.428633	1.035274	0.013559	63.109476	203.00
204.00		67,407	113,108	74,341	74,805	16,464	204.00
205.00		169.364322	0.166349	0.111241	0.001544	1.893284	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
9/24/2013 2:37 pm

		Title XVIII		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		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	10,124,627		10,124,627	10,409	10,135,036	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	294,475		294,475	0	294,475	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	476,443		476,443	0	476,443	54.00
60.00	06000 LABORATORY	473,630		473,630	0	473,630	60.00
65.00	06500 RESPIRATORY THERAPY	1,103,884	0	1,103,884	0	1,103,884	65.00
66.00	06600 PHYSICAL THERAPY	1,640,456	0	1,640,456	0	1,640,456	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,121,784		1,121,784	0	1,121,784	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,647,972		1,647,972	0	1,647,972	73.00
74.00	07400 RENAL DIALYSIS	195,183		195,183	0	195,183	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
100.00	10000 I&R SERVICES - NOT APPRVD. PRGM.	0		0		0	100.00
200.00	Subtotal (see instructions)	17,078,454	0	17,078,454	10,409	17,088,863	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	17,078,454	0	17,078,454	10,409	17,088,863	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
9/24/2013 2:37 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,604,440		17,604,440		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	659,781	0	659,781	0.446322	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,285,217	0	1,285,217	0.370710	54.00
60.00	06000	LABORATORY	3,003,033	0	3,003,033	0.157717	60.00
65.00	06500	RESPIRATORY THERAPY	8,492,054	0	8,492,054	0.129990	65.00
66.00	06600	PHYSICAL THERAPY	1,993,185	0	1,993,185	0.823032	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,466,964	0	5,466,964	0.205193	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,194,948	0	9,194,948	0.179226	73.00
74.00	07400	RENAL DIALYSIS	746,527	0	746,527	0.261455	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0		100.00
200.00		Subtotal (see instructions)	48,446,149	0	48,446,149		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	48,446,149	0	48,446,149		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet C Part I Date/Time Prepared: 9/24/2013 2:37 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.446322		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.370710		54.00
60.00	06000 LABORATORY	0.157717		60.00
65.00	06500 RESPIRATORY THERAPY	0.129990		65.00
66.00	06600 PHYSICAL THERAPY	0.823032		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.205193		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.179226		73.00
74.00	07400 RENAL DIALYSIS	0.261455		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
100.00	10000 I&R SERVICES - NOT APPRVD. PRGM.			100.00
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: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
9/24/2013 2:37 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	10,124,627		10,124,627	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	294,475		294,475	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	476,443		476,443	0	0	54.00
60.00	06000 LABORATORY	473,630		473,630	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	1,103,884	0	1,103,884	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,640,456	0	1,640,456	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,121,784		1,121,784	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,647,972		1,647,972	0	0	73.00
74.00	07400 RENAL DIALYSIS	195,183		195,183	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
100.00	10000 I&R SERVICES - NOT APPRVD. PRGM.	0		0	0	0	100.00
200.00	Subtotal (see instructions)	17,078,454	0	17,078,454	0	0	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	17,078,454	0	17,078,454	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
9/24/2013 2:37 pm

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			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	17,604,440		17,604,440		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	659,781	0	659,781	0.446322	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,285,217	0	1,285,217	0.370710	54.00
60.00	06000	LABORATORY	3,003,033	0	3,003,033	0.157717	60.00
65.00	06500	RESPIRATORY THERAPY	8,492,054	0	8,492,054	0.129990	65.00
66.00	06600	PHYSICAL THERAPY	1,993,185	0	1,993,185	0.823032	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,466,964	0	5,466,964	0.205193	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,194,948	0	9,194,948	0.179226	73.00
74.00	07400	RENAL DIALYSIS	746,527	0	746,527	0.261455	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0		100.00
200.00		Subtotal (see instructions)	48,446,149	0	48,446,149		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	48,446,149	0	48,446,149		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet C Part I Date/Time Prepared: 9/24/2013 2:37 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
100.00	10000 I&R SERVICES - NOT APPRVD. PRGM.			100.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 142013		Period: From 05/01/2012 To 04/30/2013		Worksheet D Part I Date/Time Prepared: 9/24/2013 2:37 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,326,054	0	2,326,054	8,696	267.49	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (Lines 30-199)	2,326,054		2,326,054	8,696		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	6,807	1,820,804				
31.00	INTENSIVE CARE UNIT	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (Lines 30-199)	6,807	1,820,804				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet D Part II Date/Time Prepared: 9/24/2013 2:37 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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	5,298	659,781	0.008030	466,073	3,743	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	82,371	1,285,217	0.064091	1,028,159	65,896	54.00
60.00	06000 LABORATORY	28,422	3,003,033	0.009464	2,378,303	22,508	60.00
65.00	06500 RESPIRATORY THERAPY	80,748	8,492,054	0.009509	6,568,846	62,463	65.00
66.00	06600 PHYSICAL THERAPY	759,032	1,993,185	0.380814	1,537,241	585,403	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	123,295	5,466,964	0.022553	4,178,736	94,243	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	100,525	9,194,948	0.010933	7,150,023	78,171	73.00
74.00	07400 RENAL DIALYSIS	3,926	746,527	0.005259	596,218	3,136	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (Lines 50-199)	1,183,617	30,841,709		23,903,599	915,563	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142013		Period: From 05/01/2012 To 04/30/2013		Worksheet D Part III Date/Time Prepared: 9/24/2013 2:37 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
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	8,696	0.00	6,807	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	8,696		6,807	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
9/24/2013 2:37 pm

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00	
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00	
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: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
9/24/2013 2:37 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)	Hospital		
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	659,781	0.000000	0.000000	466,073	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,285,217	0.000000	0.000000	1,028,159	54.00
60.00	06000 LABORATORY	0	3,003,033	0.000000	0.000000	2,378,303	60.00
65.00	06500 RESPIRATORY THERAPY	0	8,492,054	0.000000	0.000000	6,568,846	65.00
66.00	06600 PHYSICAL THERAPY	0	1,993,185	0.000000	0.000000	1,537,241	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,466,964	0.000000	0.000000	4,178,736	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,194,948	0.000000	0.000000	7,150,023	73.00
74.00	07400 RENAL DIALYSIS	0	746,527	0.000000	0.000000	596,218	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0.000000	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00	Total (Lines 50-199)	0	30,841,709			23,903,599	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet D Part IV Date/Time Prepared: 9/24/2013 2:37 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)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	23,723	0	54.00
60.00	06000 LABORATORY	0	6,363	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	14,126	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	144	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	23,579	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES	0	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
200.00	Total (Lines 50-199)	0	67,935	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet D Part V Date/Time Prepared: 9/24/2013 2:37 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.446322	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.370710	23,723	0	0	8,794	54.00
60.00 06000 LABORATORY	0.157717	6,363	0	0	1,004	60.00
65.00 06500 RESPIRATORY THERAPY	0.129990	14,126	0	0	1,836	65.00
66.00 06600 PHYSICAL THERAPY	0.823032	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.205193	144	0	0	30	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.179226	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.261455	23,579	0	0	6,165	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.000000	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
98.00 05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Subtotal (see instructions)	67,935	0	0	17,829	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)	67,935	0	0	17,829	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet D Part V Date/Time Prepared: 9/24/2013 2:37 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet D-1 Date/Time Prepared: 9/24/2013 2:37 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,696	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,696	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)		8,696	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		6,807	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	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)		10,135,036	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		10,135,036	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		17,604,440	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		17,604,440	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.575709	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)		2,024.43	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)		10,135,036	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,165.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,933,422	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)		7,933,422	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142013		Period: From 05/01/2012 To 04/30/2013		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 9/24/2013 2:37 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)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				5,378,151		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				13,311,573		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)				1,820,804		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				915,563		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				2,736,367		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				10,575,206		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)				0		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142013		Period: From 05/01/2012 To 04/30/2013		Worksheet D-1 Date/Time Prepared: 9/24/2013 2:37 pm	
Title XVIII		Hospital		PPS			
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00 Capital-related cost	2,326,054	10,135,036	0.229506	0	0	0	90.00
91.00 Nursing School cost	0	10,135,036	0.000000	0	0	0	91.00
92.00 Allied health cost	0	10,135,036	0.000000	0	0	0	92.00
93.00 All other Medical Education	0	10,135,036	0.000000	0	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet D-1
		Title XIX		Date/Time Prepared: 9/24/2013 2:37 pm
		Hospital		Cost
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,696	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,696	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)		8,696	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		60	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	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)		10,124,627	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		10,124,627	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		17,604,440	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		17,604,440	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.575118	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)		2,024.43	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)		10,124,627	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,164.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		69,857	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)		69,857	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet D-1 Date/Time Prepared: 9/24/2013 2:37 pm
Cost Center Description			Title XIX	Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	0	0	0.00	0	0
44.00					
45.00					
46.00					
47.00					
Cost Center Description					
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				40,698
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				110,555
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0
52.00	Total Program excludable cost (sum of lines 50 and 51)				0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/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)				0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142013		Period: From 05/01/2012 To 04/30/2013		Worksheet D-1 Date/Time Prepared: 9/24/2013 2:37 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

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet D-2

Date/Time Prepared:  
9/24/2013 2:37 pm

Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program Inpatient Days Title V															
	1.00	2.00	3.00	4.00	5.00															
<b>PART I - NOT IN APPROVED TEACHING PROGRAM</b>																				
Hospital Inpatient Routine Services:																				
1.00 Total cost of services rendered	0.00	0				1.00														
2.00 ADULTS & PEDIATRICS	0.00	0	8,696	0.00	0	2.00														
3.00 INTENSIVE CARE UNIT	0.00	0	0	0.00	0	3.00														
4.00 CORONARY CARE UNIT						4.00														
5.00 BURN INTENSIVE CARE UNIT						5.00														
6.00 SURGICAL INTENSIVE CARE UNIT						6.00														
7.00 OTHER SPECIAL CARE (SPECIFY)						7.00														
8.00 NURSERY						8.00														
9.00 Subtotal (sum of lines 2 through 8)	0.00	0				9.00														
10.00 SUBPROVIDER - IPF						10.00														
11.00 SUBPROVIDER - IRF						11.00														
12.00 SUBPROVIDER						12.00														
13.00 SKILLED NURSING FACILITY	0.00	0	0	0.00	0	13.00														
14.00 NURSING FACILITY						14.00														
15.00 OTHER LONG TERM CARE						15.00														
16.00 HOME HEALTH AGENCY						16.00														
17.00 CMHC						17.00														
18.00 AMBULATORY SURGICAL CENTER (D.P.)						18.00														
19.00 HOSPICE						19.00														
20.00 Subtotal (sum of lines 9 through 19)	0.00	0				20.00														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th></th> <th></th> <th>Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)</th> <th>Ratio of Cost to Charges (col. 2 ÷ col. 3)</th> <th>Titles V and XIX Outpatient and Title XVIII Part B Charges Title V</th> <th></th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td> </tr> </thead> </table>							Cost Center Description			Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V			1.00	2.00	3.00	4.00	5.00	
Cost Center Description			Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V															
	1.00	2.00	3.00	4.00	5.00															
Hospital Outpatient Services:																				
21.00 RURAL HEALTH CLINIC						21.00														
22.00 FEDERALLY QUALIFIED HEALTH CENTER						22.00														
23.00 CLINIC	0.00	0	0	0.000000	0	23.00														
24.00 EMERGENCY	0.00	0	0	0.000000	0	24.00														
25.00 OBSERVATION BEDS (NON-DISTINCT PART)						25.00														
26.00 OTHER OUTPATIENT SERVICE COST CENTER						26.00														
27.00 Subtotal (sum of lines 21 through 26)	0.00	0				27.00														
28.00 Total (sum of lines 20 and 27)	0.00	0				28.00														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th>Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22</th> <th>Swing bed Amount</th> <th>Net cost (column 1 plus column 2)</th> <th>Total Inpatient Days - All Patients</th> <th>Average Cost Per Day (col. 3 ÷ col. 4)</th> <th></th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td> </tr> </thead> </table>							Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)			1.00	2.00	3.00	4.00	5.00	
Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)															
	1.00	2.00	3.00	4.00	5.00															
<b>PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)</b>																				
Hospital Inpatient Routine Services:																				
29.00 ADULTS & PEDIATRICS	0	0	0	8,696	0.00	29.00														
30.00 Swing Bed - SNF				0	0.00	30.00														
31.00 Swing Bed - NF				0		31.00														
32.00 INTENSIVE CARE UNIT	0			0	0.00	32.00														
33.00 CORONARY CARE UNIT						33.00														
34.00 BURN INTENSIVE CARE UNIT						34.00														
35.00 SURGICAL INTENSIVE CARE UNIT						35.00														
36.00 OTHER SPECIAL CARE (SPECIFY)						36.00														
37.00 Subtotal (sum of lines 28, and 29 through 36)	0			0		37.00														
38.00 SUBPROVIDER - IPF						38.00														
39.00 SUBPROVIDER - IRF						39.00														
40.00 SUBPROVIDER						40.00														
41.00 SKILLED NURSING FACILITY	0			0	0.00	41.00														
42.00 Total (sum of lines 37 through 41)	0			0		42.00														

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet D-2

Date/Time Prepared:  
9/24/2013 2:37 pm

Cost Center Description	Not In Approved Teaching Program		In Approved Teaching Program	
	(from Part I:)	Amount	(from Part II, col. 7, - )	
	1.00	2.00	3.00	
<b>PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)</b>				
<b>Hospital</b>				
43.00 Inpatient	col. 9, line 9.00		0 line 37.00	43.00
44.00 Outpatient	col. 9, line 27.00		0	44.00
45.00 Total Hospital (sum of lines 43 and 44)			0	45.00
46.00 SUBPROVIDER - IPF				46.00
47.00 SUBPROVIDER - IRF				47.00
48.00 SUBPROVIDER				48.00
49.00 SKILLED NURSING FACILITY	col. 9, line 13.00		0 col. 9, line 41.00	49.00

Cost Center Description	Health Care Program Inpatient Days		Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
	Title XVIII, Part B Only Less Part A Coverage but no Part B Coverage	Title XIX				
	6.00	7.00				
<b>PART I - NOT IN APPROVED TEACHING PROGRAM</b>						
1.00	Total cost of services rendered					1.00
Hospital Inpatient Routine Services:						
2.00	ADULTS & PEDIATRICS	6,807	60	0	0	2.00
3.00	INTENSIVE CARE UNIT	0	0	0	0	3.00
4.00	CORONARY CARE UNIT					4.00
5.00	BURN INTENSIVE CARE UNIT					5.00
6.00	SURGICAL INTENSIVE CARE UNIT					6.00
7.00	OTHER SPECIAL CARE (SPECIFY)					7.00
8.00	NURSERY					8.00
9.00	Subtotal (sum of lines 2 through 8)			0	0	9.00
10.00	SUBPROVIDER - IPF					10.00
11.00	SUBPROVIDER - IRF					11.00
12.00	SUBPROVIDER					12.00
13.00	SKILLED NURSING FACILITY	0	0	0	0	13.00
14.00	NURSING FACILITY					14.00
15.00	OTHER LONG TERM CARE					15.00
16.00	HOME HEALTH AGENCY					16.00
17.00	CMHC					17.00
18.00	AMBULATORY SURGICAL CENTER (D.P.)					18.00
19.00	HOSPICE					19.00
20.00	Subtotal (sum of lines 9 through 19)					20.00
Cost Center Description		Titles V and XIX Outpatient and Title XVIII Part B Charges		Titles V and XIX Outpatient and Title XVIII Part B Cost		
		Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX
		6.00	7.00	8.00	9.00	10.00
Hospital Outpatient Services:						
21.00	RURAL HEALTH CLINIC					21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER					22.00
23.00	CLINIC	0	0	0	0	23.00
24.00	EMERGENCY	0	0	0	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)					25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER					26.00
27.00	Subtotal (sum of lines 21 through 26)			0	0	27.00
28.00	Total (sum of lines 20 and 27)					28.00
Cost Center Description		Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents		
		6.00	7.00	11.00		
<b>PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)</b>						
Hospital Inpatient Routine Services:						
29.00	ADULTS & PEDIATRICS	0	0	0		29.00
30.00	Swing Bed - SNF	0	0			30.00
31.00	Swing Bed - NF					31.00
32.00	INTENSIVE CARE UNIT	0	0	0		32.00
33.00	CORONARY CARE UNIT					33.00
34.00	BURN INTENSIVE CARE UNIT					34.00
35.00	SURGICAL INTENSIVE CARE UNIT					35.00
36.00	OTHER SPECIAL CARE (SPECIFY)					36.00
37.00	Subtotal (sum of lines 28, and 29 through 36)		0	0		37.00
38.00	SUBPROVIDER - IPF					38.00
39.00	SUBPROVIDER - IRF					39.00
40.00	SUBPROVIDER					40.00
41.00	SKILLED NURSING FACILITY	0	0	0		41.00
42.00	Total (sum of lines 37 through 41)		0	0		42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet D-2

Date/Time Prepared:  
9/24/2013 2:37 pm

Cost Center Description	In Approved Teaching Program	Total Title XVIII Costs			
	Amount	(to Wkst. E, Part B - )	(col. 2 + col. 4)		
	4.00	5.00	6.00		
<b>PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)</b>					
<b>Hospital</b>					
43.00	Inpatient	0		0	43.00
44.00	Outpatient				44.00
45.00	Total Hospital (sum of lines 43 and 44)	0	line 2.00	0	45.00
46.00	SUBPROVIDER - IPF				46.00
47.00	SUBPROVIDER - IRF				47.00
48.00	SUBPROVIDER				48.00
49.00	SKILLED NURSING FACILITY	0	line 2.00	0	49.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet D-3 Date/Time Prepared: 9/24/2013 2:37 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		13,793,098		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.446322	466,073	208,019	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.370710	1,028,159	381,149	54.00
60.00	06000 LABORATORY	0.157717	2,378,303	375,099	60.00
65.00	06500 RESPIRATORY THERAPY	0.129990	6,568,846	853,884	65.00
66.00	06600 PHYSICAL THERAPY	0.823032	1,537,241	1,265,199	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.205193	4,178,736	857,447	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.179226	7,150,023	1,281,470	73.00
74.00	07400 RENAL DIALYSIS	0.261455	596,218	155,884	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		23,903,599	5,378,151	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		23,903,599		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet D-3 Date/Time Prepared: 9/24/2013 2:37 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		123,132		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.446322	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.370710	0	0	54.00
60.00	06000 LABORATORY	0.157717	3,120	492	60.00
65.00	06500 RESPIRATORY THERAPY	0.129990	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.823032	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.205193	29,992	6,154	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.179226	189,996	34,052	73.00
74.00	07400 RENAL DIALYSIS	0.261455	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		223,108	40,698	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		223,108		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet E Part B Date/Time Prepared: 9/24/2013 2:37 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			17,829 2.00
3.00	PPS payments			14,358 3.00
4.00	Outlier payment (see instructions)			1,666 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)			0 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from 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
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			0 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)			16,024 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			3,018 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)			13,006 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)			13,006 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			13,006 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			13,006 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	AB Re-billing demo amount (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			13,006 40.00
41.00	Interim payments			13,006 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)			0 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet E-1  
Part I  
Date/Time Prepared:  
9/24/2013 2:37 pm

		Title XVIII		Hospital		PPS	
		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		11,671,787		13,006	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)		11,671,787		13,006	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		189,498		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		11,861,285		13,006	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet E-3 Part IV Date/Time Prepared: 9/24/2013 2:37 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART IV - MEDICARE PART A SERVICES - LTCH PPS</b>				
1.00	Net Federal PPS Payments (see instructions)			11,078,259 1.00
2.00	Outlier Payments			1,397,655 2.00
3.00	Total PPS Payments (sum of lines 1 and 2)			12,475,914 3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)			0 4.00
5.00	Organ acquisition			0 5.00
6.00	Cost of teaching physicians			0 6.00
7.00	Subtotal (see instructions)			12,475,914 7.00
8.00	Primary payer payments			2,288 8.00
9.00	Subtotal (line 7 less line 8)			12,473,626 9.00
10.00	Deductibles			30,224 10.00
11.00	Subtotal (line 9 minus line 10)			12,443,402 11.00
12.00	Coinsurance			771,615 12.00
13.00	Subtotal (line 11 minus line 12)			11,671,787 13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			270,711 14.00
15.00	Adjusted reimbursable bad debts (see instructions)			189,498 15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			227,824 16.00
17.00	Subtotal (sum of lines 13 and 15)			11,861,285 17.00
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Other pass through costs (see instructions)			0 19.00
20.00	Outlier payments reconciliation			0 20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 21.00
21.99	Recovery of Accelerated Depreciation			0 21.99
22.00	Total amount payable to the provider (see instructions)			11,861,285 22.00
23.00	Interim payments			11,671,787 23.00
24.00	Tentative settlement (for contractor use only)			0 24.00
25.00	Balance due provider/program (line 22 minus the sum lines 23 and 24)			189,498 25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 26.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part IV, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142013	Period: From 05/01/2012 To 04/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 9/24/2013 2:37 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		110,555		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		110,555	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		110,555	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		123,132		8.00
9.00	Ancillary service charges		223,108	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		346,240	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		346,240	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		235,685	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		110,555	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		110,555	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		110,555	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		110,555	0	36.00
37.00	OTHER ADJUSTMENTS		0	0	37.00
37.01	OTHER ADJUSTMENTS		0	0	37.01
38.00	Subtotal (line 36 ± line 37)		110,555	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		110,555	0	40.00
41.00	Interim payments		180,391	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-69,836	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet G

Date/Time Prepared:  
9/24/2013 2:37 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	2,145,167	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,069,705	0	0	0	4.00
5.00	Other receivable	2,038	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-788,847	0	0	0	6.00
7.00	Inventory	190,641	0	0	0	7.00
8.00	Prepaid expenses	150,669	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)	5,769,373	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	197,980	0	0	0	17.00
18.00	Accumulated depreciation	-55,576	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	562,136	0	0	0	23.00
24.00	Accumulated depreciation	-184,923	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	519,617	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	983,082	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	983,082	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	7,272,072	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	367,994	0	0	0	37.00
38.00	Salaries, wages, and fees payable	395,180	0	0	0	38.00
39.00	Payroll taxes payable	64,549	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	605,595	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,433,318	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,079,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,079,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,512,318	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	3,759,754				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	3,759,754	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	7,272,072	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet G-1

Date/Time Prepared:  
9/24/2013 2:37 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		6,158,282		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-97,098			2.00
3.00	Total (sum of line 1 and line 2)		6,061,184		0	3.00
4.00	Additions (credit adjustments)	0		0		4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	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)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		6,061,184		0	11.00
12.00	Deductions (debit adjustments)	0		0		12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	2,301,430		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)		2,301,430		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,759,754		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	Additions (credit adjustments)		0			4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING		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)		0			12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING		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: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
9/24/2013 2:37 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	17,604,440		17,604,440	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	0		0	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)	17,604,440		17,604,440	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	17,604,440		17,604,440	17.00
18.00	Ancillary services	30,841,709	0	30,841,709	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	48,446,149	0	48,446,149	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,853,145		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		16,853,145		43.00

## STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 142013

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet G-3

Date/Time Prepared:  
9/24/2013 2:37 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	48,446,149	1.00
2.00	Less contractual allowances and discounts on patients' accounts	32,555,818	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,890,331	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,853,145	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-962,814	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	295	6.00
7.00	Income from investments	208	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	677	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	16,671	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	918	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	12,345	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	834,602	24.00
25.00	Total other income (sum of lines 6-24)	865,716	25.00
26.00	Total (line 5 plus line 25)	-97,098	26.00
27.00	OTHER EXPENSES	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)	-97,098	29.00