

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: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet S Parts I-III Date/Time Prepared: 1/21/2014 1:28 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 1/21/2014	Time: 1:28 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 St. Louis (262010) for the cost reporting period beginning 09/01/2012 and ending 08/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	376,821	-4,698	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	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	376,821	-4,698	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 262010		Period: From 09/01/2012 To 08/31/2013		Worksheet S-2 Part I Date/Time Prepared: 1/20/2014 6:07 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 4930 Lindell Boulevard			PO Box:						1.00		
2.00	City: St. Louis			State: MO		Zip Code: 63108		County: St. Louis City		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00		3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		Kindred Hospital St. Louis		262010	41180	2	08/30/1991	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:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2012	08/31/2013		20.00		
21.00	Type of Control (see instructions)						4		21.00			
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N	N		22.00		
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 days	Medicaid HMO days	Other Medicaid days					
1.00		2.00	3.00	4.00	5.00	6.00						
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		0	0	0	0	0		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		25.00			
							Urban/Rural S	Date of Geogr				
							1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1		26.00			
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1		27.00			
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00			

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		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
		1.00				
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00
62.01	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
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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
		0.00	0.00	0.000000		64.00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	0.00				0.00
						0.000000
		Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					Y	80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			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

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		V	XIX			
		1.00	2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				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	
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	
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	
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	43,299	4,689	187,231		
		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		
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	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	189003		

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1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: KINDRED HEALTHCARE INC	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		Contractor's Number: 05901			
142.00	Street: 680 SOUTH FOURTH AVENUE	PO Box:					
143.00	City: LOUISVILLE	State: KY		Zip Code: 40202			
				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	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						
166.01							
166.02							
166.03							
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				N	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				0	168.00	
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	
				Beginni ng		Endi ng	
				1.00		2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet S-2 Part II Date/Time Prepared: 1/20/2014 6:07 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.			Y	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	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	12/31/2013	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet S-2 Part II Date/Time Prepared: 1/20/2014 6:07 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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
Interest Expense					
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
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			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
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		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
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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		
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)	12/31/2013		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	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
1/20/2014 6:07 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	95	34,675	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		95	34,675	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)		95	34,675	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
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		95				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: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
1/20/2014 6:07 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,170	2,412	17,558			1.00
2.00 HMO and other (see instructions)	406	100				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)	9,170	2,412	17,558			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)	9,170	2,412	17,558	0.00	188.60	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
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	188.60	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	133					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
1/20/2014 6:07 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)(see instructions for col. 2 for the portion of LDP room available beds)			0	365	69	634	1.00
2.00 HMO and other (see instructions)				18			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		365	69	634	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
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 262010		Period: From 09/01/2012 To 08/31/2013		Worksheet S-3 Part II Date/Time Prepared: 1/20/2014 6:07 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		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	10,648,071	25,047	10,673,118	392,754.00	27.18	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	97,495	97,495	2,725.00	35.78	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		2,224,256	0	2,224,256	47,219.00	47.11	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		960,176	0	960,176	9,372.00	102.45	13.00
14.00	Home office salaries & wage-related costs		1,042,385	0	1,042,385	21,834.00	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
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		1,837,667	0	1,837,667			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		16,981	0	16,981			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
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	81,549	0	81,549	3,122.00	26.12	26.00
27.00	Administrative & General	5.00	1,502,856	25,047	1,527,903	38,484.00	39.70	27.00
28.00	Administrative & General under contract (see inst.)		2,845	0	2,845	99.00	28.74	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	24,248	0	24,248	767.00	31.61	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	217,120	0	217,120	16,232.00	13.38	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	211,864	0	211,864	13,407.00	15.80	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	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	1,364,318	0	1,364,318	34,603.00	39.43	38.00
39.00	Central Services and Supply	14.00	110,301	0	110,301	6,159.00	17.91	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	395,765	0	395,765	13,827.00	28.62	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet S-3
Part II
Date/Time Prepared:
1/20/2014 6:07 pm

		Worksheet A Line Number	Amount Reported	Reclassifi- 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	
42.00	Social Service	17.00	699,449	-97,495	601,954	16,828.00	35.77	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet S-3
Part III
Date/Time Prepared:
1/20/2014 6:07 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	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	10,650,916	25,047	10,675,963	392,853.00	27.18	1.00
2.00	Excluded area salaries (see instructions)	0	97,495	97,495	2,725.00	35.78	2.00
3.00	Subtotal salaries (line 1 minus line 2)	10,650,916	-72,448	10,578,468	390,128.00	27.12	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,226,817	0	4,226,817	78,425.00	53.90	4.00
5.00	Subtotal wage-related costs (see inst.)	1,837,667	0	1,837,667	0.00	17.37	5.00
6.00	Total (sum of lines 3 thru 5)	16,715,400	-72,448	16,642,952	468,553.00	35.52	6.00
7.00	Total overhead cost (see instructions)	4,610,315	-72,448	4,537,867	143,528.00	31.62	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet S-3 Part IV Date/Time Prepared: 1/20/2014 6:07 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	-561	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
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
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
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	613,905	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	112	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	8,601	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)	36,783	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	231,517	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
TAXES			
17.00	FICA-Employers Portion Only	769,818	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	139,116	20.00
OTHER			
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	38,375	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,837,666	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet S-7

Date/Time Prepared:
1/20/2014 6:07 pm

		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: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet S-7

Date/Time Prepared:
1/20/2014 6:07 pm

		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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet S-10 Date/Time Prepared: 1/20/2014 6:07 pm
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				1.00		
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.287788	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			0	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00	
6.00	Medicaid charges			0	6.00	
7.00	Medicaid cost (line 1 times line 6)			0	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			0	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone SCHIP			0	9.00	
10.00	Stand-alone SCHIP charges			0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			0	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0	0	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0	0	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	0	0	0	23.00
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?					24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			0	0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			487,007		27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)			-487,007		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			-140,155		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			-140,155		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			-140,155		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet A
Date/Time Prepared:
1/20/2014 6:07 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		2,751,750	2,751,750	47,762	2,799,512	1.00
2.00	00200		674,041	674,041	192,064	866,105	2.00
3.00	00300		239,826	239,826	-239,826	0	3.00
4.00	00400	81,549	1,985,476	2,067,025	-25,047	2,041,978	4.00
5.00	00500	1,502,856	5,397,449	6,900,305	25,047	6,925,352	5.00
7.00	00700	24,248	595,817	620,065	0	620,065	7.00
8.00	00800	0	144,407	144,407	0	144,407	8.00
9.00	00900	217,120	106,505	323,625	0	323,625	9.00
10.00	01000	211,864	304,604	516,468	0	516,468	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	1,364,318	18,922	1,383,240	0	1,383,240	13.00
14.00	01400	110,301	14,605	124,906	0	124,906	14.00
15.00	01500	0	1,199,458	1,199,458	0	1,199,458	15.00
16.00	01600	395,765	74,844	470,609	0	470,609	16.00
17.00	01700	699,449	87,909	787,358	-109,627	677,731	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,649,680	1,009,410	5,659,090	0	5,659,090	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	216,626	216,626	0	216,626	50.00
54.00	05400	74,296	261,563	335,859	0	335,859	54.00
60.00	06000	80,148	435,070	515,218	0	515,218	60.00
65.00	06500	1,236,477	67,703	1,304,180	0	1,304,180	65.00
66.00	06600	0	1,088,889	1,088,889	0	1,088,889	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	957,308	957,308	0	957,308	71.00
73.00	07300	0	1,347,680	1,347,680	0	1,347,680	73.00
74.00	07400	0	427,870	427,870	0	427,870	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09500	0	0	0	0	0	98.00
100.00	10000	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		10,648,071	19,407,732	30,055,803	-109,627	29,946,176	118.00
NONREIMBURSABLE COST CENTERS							
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	109,627	109,627	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		10,648,071	19,407,732	30,055,803	0	30,055,803	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet A
Date/Time Prepared:
1/20/2014 6:07 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	80,966	2,880,478	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-102,452	763,653	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-836	2,041,142	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-715,313	6,210,039	5.00
7.00	00700	OPERATION OF PLANT	-1,061	619,004	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	144,407	8.00
9.00	00900	HOUSEKEEPING	0	323,625	9.00
10.00	01000	DIETARY	-6,927	509,541	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,383,240	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	124,906	14.00
15.00	01500	PHARMACY	0	1,199,458	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,737	473,346	16.00
17.00	01700	SOCIAL SERVICE	-870	676,861	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-150,623	5,508,467	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	0	216,626	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	335,859	54.00
60.00	06000	LABORATORY	0	515,218	60.00
65.00	06500	RESPIRATORY THERAPY	-619	1,303,561	65.00
66.00	06600	PHYSICAL THERAPY	-75,103	1,013,786	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	957,308	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,347,680	73.00
74.00	07400	RENAL DIALYSIS	-1,519	426,351	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS					
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
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-971,620	28,974,556	118.00
NONREIMBURSABLE COST CENTERS					
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	109,627	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)	-971,620	29,084,183	200.00

RECLASSIFICATIONS

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-6

Date/Time Prepared:
1/20/2014 6:07 pm

Increases						
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
A - RECLASS NON ALLOWABLE CASE MANAGER						
1.00	NONALLOWABLE CASE MANAGER	194.00	97,495	12,132		1.00
	TOTALS		97,495	12,132		
F - RECLASS HEPAP BONUS TO SALARY						
1.00	ADMINISTRATIVE & GENERAL	5.00	597	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	24,450	0		2.00
	TOTALS		25,047	0		
500.00	Grand Total: Increases		122,542	12,132		500.00

RECLASSIFICATIONS

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-6
Date/Time Prepared:
1/20/2014 6:07 pm

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - RECLASS NON ALLOWABLE CASE MANAGER							
1.00	SOCIAL SERVICE	17.00	97,495	12,132	0		1.00
	TOTALS		97,495	12,132			
F - RECLASS HEPAP BONUS TO SALARY							
1.00	EMPLOYEE BENEFITS	4.00	0	597	0		1.00
2.00	EMPLOYEE BENEFITS	4.00	0	24,450	0		2.00
	TOTALS		0	25,047			
500.00	Grand Total: Decreases		97,495	37,179			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-7
Part I
Date/Time Prepared:
1/20/2014 6:07 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	1,201,998	131,591	0	131,591	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	4,782,205	90,224	0	90,224	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	5,984,203	221,815	0	221,815	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	5,984,203	221,815	0	221,815	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
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	1,210,392	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	4,867,313	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	6,077,705	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	6,077,705	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-7
Part II
Date/Time Prepared:
1/20/2014 6:07 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	75,156	2,676,594	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	361,433	312,608	0	0	0	2.00
3.00	Total (sum of lines 1-2)	436,589	2,989,202	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	2,751,750				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	674,041				2.00
3.00	Total (sum of lines 1-2)	0	3,425,791				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-7
Part III
Date/Time Prepared:
1/20/2014 6:07 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	1,210,393	0	1,210,393	0.199153	5,640	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,867,313	0	4,867,313	0.800847	22,678	2.00
3.00	Total (sum of lines 1-2)	6,077,706	0	6,077,706	1.000000	28,318	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	42,122	0	47,762	161,078	2,676,594	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	169,386	0	192,064	258,981	312,608	2.00
3.00	Total (sum of lines 1-2)	211,508	0	239,826	420,059	2,989,202	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	684	42,122	0	2,880,478	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	22,678	169,386	0	763,653	2.00
3.00	Total (sum of lines 1-2)	0	23,362	211,508	0	3,644,131	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-8

Date/Time Prepared:
1/20/2014 6:07 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)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-2,727		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	-23,705		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-1,061		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	-197,760				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	-72,088				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-6,625		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	-2,886		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	-302		DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00			0		0.00	0	33.00
33.01 MISCELLANEOUS INCOME	B	-28,158		ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-8

Date/Time Prepared:
1/20/2014 6:07 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
33.02		0		0.00	0	33.02
33.03		0		0.00	0	33.03
33.04		0		0.00	0	33.04
33.05	OCCUPATIONAL INCENTIVE INCOME	-30,754	ADMINISTRATIVE & GENERAL	5.00	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	-697,880	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09		0		0.00	0	33.09
33.10	OTHER MEDICARE NON ALLOWABLE	-41,875	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	-228	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	OTHER OPERATING - PUBLIC RELATIONS	-542	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	OTHER OPERATING - MARKETING	-39,445	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	-440	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	-5,000	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	OTHER OPER - PROP RESERVE ADJUST	-113,856	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27		0		0.00	0	33.27
33.28	AGGREGATE CAPITAL EROSION	-5,793	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	CABLE TV AND SATELLITE	-6,322	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	57,553	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33		0		0.00	0	33.33
33.34	MALPRACTICE TAIL LIABILITY	40,421	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	AGGREGATE CAP PYMT-NONALLOWABLE	27,966	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36		0		0.00	0	33.36
33.37	PHYSICIAN BILLING COLLECTION FEES	-4,009	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	84,156	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
34.01	MEDICARE VS BOOK MOV EQUIP	-141,542	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.01
34.02	ASSET ADD-ON BLDG	1,414	CAP REL COSTS-BLDG & FIXT	1.00	9	34.02
34.03	ASSET ADD-ON MOV EQUIP	42,389	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.03
34.04		0		0.00	0	34.04
34.05		0		0.00	0	34.05
34.06	NON ALLOWABLE LOBBYING FEES	-11,715	ADMINISTRATIVE & GENERAL	5.00	0	34.06
34.07		0		0.00	0	34.07
34.08	BUSINESS INTERRUPTION INS PREMIUM	-4,956	CAP REL COSTS-BLDG & FIXT	1.00	12	34.08
34.09		0		0.00	0	34.09
34.10	FRA TAX-ADJUST TO ACTUAL	222,416	ADMINISTRATIVE & GENERAL	5.00	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	-3,299	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.14
34.15		0		0.00	0	34.15
34.16	OVERSTMT DUE TO DIFF GAAP VS AHA	352	CAP REL COSTS-BLDG & FIXT	1.00	9	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

Provider CCN: 262010

Period:
 From 09/01/2012
 To 08/31/2013

Worksheet A-8

Date/Time Prepared:
 1/20/2014 6:07 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	
34.22 DISTRICT OFFICE SALES AND MARKETING	A	-4,483	ADMINISTRATIVE & GENERAL	5.00	0 34.22
34.23 DISTRICT OFC SALES AND MKT BENEFITS	A	-836	EMPLOYEE BENEFITS	4.00	0 34.23
34.24		0		0.00	0 34.24
35.00		0		0.00	0 35.00
35.01 PHYSICIAN FEE ADJUSTMENT	A	-49,752	ADMINISTRATIVE & GENERAL	5.00	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	9,596	MEDICAL RECORDS & LIBRARY	16.00	0 35.09
35.10 PHYSICIAN FEE ADJUSTMENT	A	-870	SOCIAL SERVICE	17.00	0 35.10
35.11 PHYSICIAN FEE ADJUSTMENT	A	-3,670	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 PHYSICIAN FEE ADJUSTMENT	A	22,200	RADIOLOGY-DIAGNOSTIC	54.00	0 35.15
35.16		0		0.00	0 35.16
35.17 PHYSICIAN FEE ADJUSTMENT	A	22,496	RESPIRATORY THERAPY	65.00	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.)		-971,620			50.00

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

Provider CCN: 262010

Period: From 09/01/2012 To 08/31/2013

Worksheet A-8-1

Date/Time Prepared: 1/20/2014 6:07 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	1,602,166	1,599,151 1.00
2.00	4.00	EMPLOYEE BENEFITS	Workers Comp Premium	222,339	222,339 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	200,887	200,887 3.00
4.00	0.00			0	0 4.00
4.01	66.00	PHYSICAL THERAPY	Therapy Services	1,006,742	1,081,845 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			3,032,134	3,104,222 5.00

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

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

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

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

6.00	B	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	B	Kindred Inc-Hos	100.00	RehabCare	100.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-8-1

Date/Time Prepared:
1/20/2014 6:07 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	3,015	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	-75,103	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	-72,088			5.00

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

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

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

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

6.00	HomeOffice Cost		6.00
7.00	Worker Comp Ins		7.00
8.00	Liability Insur		8.00
9.00			9.00
10.00	Therapy Svcs		10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-8-2

Date/Time Prepared:
1/20/2014 6:07 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	541,100	0	541,100	177,200	5,411	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	74.00	DR. C	2,249	0	2,249	177,200	15	3.00
4.00	30.00	DR. D	4,060	0	4,060	177,200	28	4.00
5.00	30.00	DR. E	5,580	0	5,580	177,200	32	5.00
6.00	30.00	DR. F	10,631	0	10,631	177,200	79	6.00
7.00	30.00	DR. G	7,420	0	7,420	177,200	50	7.00
8.00	54.00	DR. H	22,200	22,200	0	225,300	0	8.00
9.00	65.00	DR. I	2,580	2,580	0	177,200	0	9.00
10.00	65.00	DR. J	1,215	0	1,215	177,200	7	10.00
11.00	30.00	DR. K	1,821	0	1,821	177,200	12	11.00
12.00	30.00	DR. L	357,875	0	357,875	177,200	3,579	12.00
13.00	74.00	DR. M	1,400	0	1,400	177,200	10	13.00
14.00	16.00	DR. N	9,596	0	9,596	177,200	66	14.00
15.00	65.00	DR. O	5,735	5,735	0	177,200	0	15.00
16.00	65.00	DR. P	3,424	3,424	0	177,200	0	16.00
17.00	65.00	DR. Q	5,514	5,514	0	177,200	0	17.00
18.00	65.00	DR. R	7,628	0	7,628	177,200	28	18.00
19.00	30.00	DR. S	1,711	0	1,711	177,200	9	19.00
20.00	30.00	DR. T	1,120	0	1,120	177,200	7	20.00
200.00			992,859	39,453	953,406		9,333	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	460,976	23,049	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	74.00	DR. C	1,278	64	0	0	0	3.00
4.00	30.00	DR. D	2,385	119	0	0	0	4.00
5.00	30.00	DR. E	2,726	136	0	0	0	5.00
6.00	30.00	DR. F	6,730	337	0	0	0	6.00
7.00	30.00	DR. G	4,260	213	0	0	0	7.00
8.00	54.00	DR. H	0	0	0	0	0	8.00
9.00	65.00	DR. I	0	0	0	0	0	9.00
10.00	65.00	DR. J	596	30	0	0	0	10.00
11.00	30.00	DR. K	1,022	51	0	0	0	11.00
12.00	30.00	DR. L	304,903	15,245	0	0	0	12.00
13.00	74.00	DR. M	852	43	0	0	0	13.00
14.00	16.00	DR. N	5,623	281	0	0	0	14.00
15.00	65.00	DR. O	0	0	0	0	0	15.00
16.00	65.00	DR. P	0	0	0	0	0	16.00
17.00	65.00	DR. Q	0	0	0	0	0	17.00
18.00	65.00	DR. R	2,385	119	0	0	0	18.00
19.00	30.00	DR. S	767	38	0	0	0	19.00
20.00	30.00	DR. T	596	30	0	0	0	20.00
200.00			795,099	39,755	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	460,976	80,124	80,124	1.00
2.00	0.00		0	0	0	0	2.00
3.00	74.00	DR. C	0	1,278	971	971	3.00
4.00	30.00	DR. D	0	2,385	1,675	1,675	4.00
5.00	30.00	DR. E	0	2,726	2,854	2,854	5.00
6.00	30.00	DR. F	0	6,730	3,901	3,901	6.00
7.00	30.00	DR. G	0	4,260	3,160	3,160	7.00
8.00	54.00	DR. H	0	0	0	22,200	8.00
9.00	65.00	DR. I	0	0	0	2,580	9.00
10.00	65.00	DR. J	0	596	619	619	10.00
11.00	30.00	DR. K	0	1,022	799	799	11.00
12.00	30.00	DR. L	0	304,903	52,972	52,972	12.00
13.00	74.00	DR. M	0	852	548	548	13.00
14.00	16.00	DR. N	0	5,623	3,973	3,973	14.00
15.00	65.00	DR. O	0	0	0	5,735	15.00
16.00	65.00	DR. P	0	0	0	3,424	16.00
17.00	65.00	DR. Q	0	0	0	5,514	17.00
18.00	65.00	DR. R	0	2,385	5,243	5,243	18.00
19.00	30.00	DR. S	0	767	944	944	19.00
20.00	30.00	DR. T	0	596	524	524	20.00
200.00			0	795,099	158,307	197,760	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet B
Part I
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,880,478	2,880,478			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	763,653		763,653		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,041,142	8,190	2,171	2,051,503	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,210,039	466,106	123,571	295,943	5.00
7.00 00700	OPERATION OF PLANT	619,004	150,258	39,836	4,697	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	144,407	62,214	16,494	0	8.00
9.00 00900	HOUSEKEEPING	323,625	43,628	11,566	42,054	9.00
10.00 01000	DIETARY	509,541	97,915	25,958	41,036	10.00
11.00 01100	CAFETERIA	0	36,961	9,799	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,383,240	93,242	24,720	264,257	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	124,906	175,249	46,461	21,364	14.00
15.00 01500	PHARMACY	1,199,458	175,774	46,600	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	473,346	65,469	17,357	76,657	16.00
17.00 01700	SOCIAL SERVICE	676,861	41,423	10,982	116,594	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,508,467	1,189,731	315,413	900,606	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
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	216,626	21,945	5,818	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	335,859	42,683	11,316	14,391	54.00
60.00 06000	LABORATORY	515,218	52,186	13,835	15,524	60.00
65.00 06500	RESPIRATORY THERAPY	1,303,561	67,202	17,816	239,496	65.00
66.00 06600	PHYSICAL THERAPY	1,013,786	49,876	13,223	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	957,308	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,347,680	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	426,351	40,426	10,717	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
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
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	28,974,556	2,880,478	763,653	2,032,619	118.00
NONREIMBURSABLE COST CENTERS						
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	109,627	0	0	18,884	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		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	29,084,183	2,880,478	763,653	2,051,503	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

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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	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,095,659				5.00
7.00	00700	OPERATION OF PLANT	262,610	1,076,405			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	71,999	29,685	324,799		8.00
9.00	00900	HOUSEKEEPING	135,815	20,817	0	577,505	9.00
10.00	01000	DIETARY	217,644	46,720	0	26,300	965,114
11.00	01100	CAFETERIA	15,089	17,636	0	9,928	117,032
13.00	01300	NURSING ADMINISTRATION	569,710	44,490	0	25,045	0
14.00	01400	CENTRAL SERVICES & SUPPLY	118,746	83,619	0	47,071	0
15.00	01500	PHARMACY	458,822	83,870	0	47,212	0
16.00	01600	MEDICAL RECORDS & LIBRARY	204,213	31,238	0	17,585	0
17.00	01700	SOCIAL SERVICE	272,957	19,765	0	11,126	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,553,909	567,676	324,799	319,557	848,082
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	78,864	10,471	0	5,894	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	130,450	20,366	0	11,465	0
60.00	06000	LABORATORY	192,574	24,900	0	14,017	0
65.00	06500	RESPIRATORY THERAPY	525,377	32,065	0	18,050	0
66.00	06600	PHYSICAL THERAPY	347,509	23,798	0	13,397	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	308,921	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	434,894	0	0	0	0
74.00	07400	RENAL DIALYSIS	154,086	19,289	0	10,858	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
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
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,054,189	1,076,405	324,799	577,505	965,114
NONREIMBURSABLE COST CENTERS							
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	41,470	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	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					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	7,095,659	1,076,405	324,799	577,505	965,114

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 262010

Period:
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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	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	206,445					11.00
13.00	01300	22,642	2,427,346				13.00
14.00	01400	3,996	0	621,412			14.00
15.00	01500	0	0	13,195	2,024,931		15.00
16.00	01600	9,323	0	326	0	895,514	16.00
17.00	01700	11,987	0	953	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	125,199	2,427,346	15,881	0	267,939	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	7,322	50.00
54.00	05400	1,332	0	1,649	0	10,724	54.00
60.00	06000	2,664	0	10,862	0	74,555	60.00
65.00	06500	29,302	0	13,521	0	212,135	65.00
66.00	06600	0	0	2,426	0	46,382	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	562,430	0	74,799	71.00
73.00	07300	0	0	0	2,024,931	191,686	73.00
74.00	07400	0	0	169	0	9,972	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09500	0	0	0	0	0	98.00
100.00	10000	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		206,445	2,427,346	621,412	2,024,931	895,514	118.00
NONREIMBURSABLE COST CENTERS							
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		206,445	2,427,346	621,412	2,024,931	895,514	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 262010

Period:
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	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	1,162,648				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	1,162,648	16,527,253	0	16,527,253	30.00
31.00	03100	0	0	0	0	31.00
44.00	04400	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	346,940	0	346,940	50.00
54.00	05400	0	580,235	0	580,235	54.00
60.00	06000	0	916,335	0	916,335	60.00
65.00	06500	0	2,458,525	0	2,458,525	65.00
66.00	06600	0	1,510,397	0	1,510,397	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
71.00	07100	0	1,903,458	0	1,903,458	71.00
73.00	07300	0	3,999,191	0	3,999,191	73.00
74.00	07400	0	671,868	0	671,868	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	0	0	0	0	90.00
91.00	09100	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	0	0	0	0	95.00
98.00	09800	0	0	0	0	98.00
100.00	10000	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00		1,162,648	28,914,202	0	28,914,202	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
194.00	07950	0	169,981	0	169,981	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	0	0	0	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		1,162,648	29,084,183	0	29,084,183	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 262010

Period: From 09/01/2012 To 08/31/2013

Worksheet B Part II Date/Time Prepared: 1/20/2014 6:07 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,190	2,171	10,361	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	178,271	466,106	123,571	767,948	5.00
7.00 00700	OPERATION OF PLANT	0	150,258	39,836	190,094	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	62,214	16,494	78,708	8.00
9.00 00900	HOUSEKEEPING	0	43,628	11,566	55,194	9.00
10.00 01000	DIETARY	0	97,915	25,958	123,873	10.00
11.00 01100	CAFETERIA	0	36,961	9,799	46,760	11.00
13.00 01300	NURSING ADMINISTRATION	0	93,242	24,720	117,962	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	175,249	46,461	221,710	14.00
15.00 01500	PHARMACY	0	175,774	46,600	222,374	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	65,469	17,357	82,826	16.00
17.00 01700	SOCIAL SERVICE	0	41,423	10,982	52,405	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,189,731	315,413	1,505,144	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
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	21,945	5,818	27,763	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	42,683	11,316	53,999	54.00
60.00 06000	LABORATORY	0	52,186	13,835	66,021	60.00
65.00 06500	RESPIRATORY THERAPY	0	67,202	17,816	85,018	65.00
66.00 06600	PHYSICAL THERAPY	0	49,876	13,223	63,099	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	40,426	10,717	51,143	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
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
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	178,271	2,880,478	763,653	3,822,402	118.00
NONREIMBURSABLE COST CENTERS						
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	0	0	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				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	178,271	2,880,478	763,653	3,822,402	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet B Part II Date/Time Prepared: 1/20/2014 6:07 pm		
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	769,442			5.00
7.00	00700	OPERATION OF PLANT	28,477	218,595		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,807	6,028	92,543	8.00
9.00	00900	HOUSEKEEPING	14,728	4,228	0	74,362
10.00	01000	DIETARY	23,601	9,488	0	3,386
11.00	01100	CAFETERIA	1,636	3,581	0	1,278
13.00	01300	NURSING ADMINISTRATION	61,779	9,035	0	3,225
14.00	01400	CENTRAL SERVICES & SUPPLY	12,877	16,981	0	6,061
15.00	01500	PHARMACY	49,754	17,032	0	6,079
16.00	01600	MEDICAL RECORDS & LIBRARY	22,145	6,344	0	2,264
17.00	01700	SOCIAL SERVICE	29,599	4,014	0	1,433
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	276,940	115,283	92,543	41,149
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,552	2,126	0	759
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,146	4,136	0	1,476
60.00	06000	LABORATORY	20,883	5,057	0	1,805
65.00	06500	RESPIRATORY THERAPY	56,971	6,512	0	2,324
66.00	06600	PHYSICAL THERAPY	37,683	4,833	0	1,725
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,499	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	47,159	0	0	0
74.00	07400	RENAL DIALYSIS	16,709	3,917	0	1,398
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	764,945	218,595	92,543	74,362
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	4,497	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0
194.09	07958	VISITOR MEALS	0	0	0	0
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0
200.00		Cross Foot Adjustments				
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	769,442	218,595	92,543	74,362

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 262010		Period: From 09/01/2012 To 08/31/2013		Worksheet B Part II Date/Time Prepared: 1/20/2014 6:07 pm	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	72,724					11.00
13.00	01300	NURSING ADMINISTRATION	7,976	201,311				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,408	0	259,145			14.00
15.00	01500	PHARMACY	0	0	5,503	300,742		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,284	0	136	0	117,386	16.00
17.00	01700	SOCIAL SERVICE	4,223	0	397	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,104	201,311	6,623	0	35,146	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
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	960	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	469	0	688	0	1,405	54.00
60.00	06000	LABORATORY	938	0	4,530	0	9,770	60.00
65.00	06500	RESPIRATORY THERAPY	10,322	0	5,639	0	27,799	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,012	0	6,078	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	234,546	0	9,802	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	300,742	25,119	73.00
74.00	07400	RENAL DIALYSIS	0	0	71	0	1,307	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
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	72,724	201,311	259,145	300,742	117,386	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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	0	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	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	72,724	201,311	259,145	300,742	117,386	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet B Part II Date/Time Prepared: 1/20/2014 6:07 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		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
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	92,660			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	92,660	2,556,540	0	2,556,540	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
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	40,160	0	40,160	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	76,392	0	76,392	54.00
60.00	06000	LABORATORY	0	109,082	0	109,082	60.00
65.00	06500	RESPIRATORY THERAPY	0	195,794	0	195,794	65.00
66.00	06600	PHYSICAL THERAPY	0	114,430	0	114,430	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	277,847	0	277,847	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	373,020	0	373,020	73.00
74.00	07400	RENAL DIALYSIS	0	74,545	0	74,545	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
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
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	92,660	3,817,810	0	3,817,810	118.00
NONREIMBURSABLE COST CENTERS							
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	4,592	0	4,592	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	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	92,660	3,822,402	0	3,822,402	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet B-1
Date/Time Prepared:
1/20/2014 6:07 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	54,865				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		54,865			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	156	156	10,591,569		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,878	8,878	1,527,903	-7,095,659	5.00
7.00 00700	OPERATION OF PLANT	2,862	2,862	24,248	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,185	1,185	0	0	8.00
9.00 00900	HOUSEKEEPING	831	831	217,120	0	9.00
10.00 01000	DIETARY	1,865	1,865	211,864	0	10.00
11.00 01100	CAFETERIA	704	704	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,776	1,776	1,364,318	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	3,338	3,338	110,301	0	14.00
15.00 01500	PHARMACY	3,348	3,348	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,247	1,247	395,765	0	16.00
17.00 01700	SOCIAL SERVICE	789	789	601,954	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	22,661	22,661	4,649,680	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
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	418	418	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	813	813	74,296	0	54.00
60.00 06000	LABORATORY	994	994	80,148	0	60.00
65.00 06500	RESPIRATORY THERAPY	1,280	1,280	1,236,477	0	65.00
66.00 06600	PHYSICAL THERAPY	950	950	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	770	770	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
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
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	54,865	54,865	10,494,074	-7,095,659	21,860,013
NONREIMBURSABLE COST CENTERS						
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	0	97,495	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)	2,880,478	763,653	2,051,503		7,095,659
203.00	Unit cost multiplier (Wkst. B, Part I)	52.501194	13.918764	0.193692		0.322698
204.00	Cost to be allocated (per Wkst. B, Part II)			10,361		769,442
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000978		0.034993

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet B-1

Date/Time Prepared:
1/20/2014 6:07 pm

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	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	42,969				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,185	17,558			8.00
9.00	00900	HOUSEKEEPING	831	0	40,953		9.00
10.00	01000	DIETARY	1,865	0	1,865	18,662	10.00
11.00	01100	CAFETERIA	704	0	704	2,263	155
13.00	01300	NURSING ADMINISTRATION	1,776	0	1,776	0	17
14.00	01400	CENTRAL SERVICES & SUPPLY	3,338	0	3,338	0	3
15.00	01500	PHARMACY	3,348	0	3,348	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,247	0	1,247	0	7
17.00	01700	SOCIAL SERVICE	789	0	789	0	9
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,661	17,558	22,661	16,399	94
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	418	0	418	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	813	0	813	0	1
60.00	06000	LABORATORY	994	0	994	0	2
65.00	06500	RESPIRATORY THERAPY	1,280	0	1,280	0	22
66.00	06600	PHYSICAL THERAPY	950	0	950	0	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	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	770	0	770	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09500	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,969	17,558	40,953	18,662	155
NONREIMBURSABLE COST CENTERS							
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	0	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	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					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,076,405	324,799	577,505	965,114	206,445
203.00		Unit cost multiplier (Wkst. B, Part I)	25.050734	18.498633	14.101653	51.715465	1,331.903226
204.00		Cost to be allocated (per Wkst. B, Part II)	218,595	92,543	74,362	160,555	72,724
205.00		Unit cost multiplier (Wkst. B, Part II)	5.087272	5.270703	1.815789	8.603312	469.187097

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet B-1

Date/Time Prepared:
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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	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	938					13.00
14.00	01400	0	1,057,704				14.00
15.00	01500	0	22,460	1,347,680			15.00
16.00	01600	0	555	0	100,470,386		16.00
17.00	01700	0	1,622	0	0	17,558	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	938	27,031	0	30,059,042	17,558	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	821,529	0	50.00
54.00	05400	0	2,807	0	1,203,225	0	54.00
60.00	06000	0	18,489	0	8,364,802	0	60.00
65.00	06500	0	23,014	0	23,800,595	0	65.00
66.00	06600	0	4,130	0	5,203,894	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	957,308	0	8,392,170	0	71.00
73.00	07300	0	0	1,347,680	21,506,324	0	73.00
74.00	07400	0	288	0	1,118,805	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
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
SPECIAL PURPOSE COST CENTERS							
118.00		938	1,057,704	1,347,680	100,470,386	17,558	118.00
NONREIMBURSABLE COST CENTERS							
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		2,427,346	621,412	2,024,931	895,514	1,162,648	202.00
203.00		2,587.788913	0.587510	1.502531	0.008913	66.217565	203.00
204.00		201,311	259,145	300,742	117,386	92,660	204.00
205.00		214.617271	0.245007	0.223155	0.001168	5.277366	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet C
Part I
Date/Time Prepared:
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		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		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	16,527,253		16,527,253	146,953	16,674,206	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
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	346,940		346,940	0	346,940	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	580,235		580,235	0	580,235	54.00
60.00	06000 LABORATORY	916,335		916,335	0	916,335	60.00
65.00	06500 RESPIRATORY THERAPY	2,458,525	0	2,458,525	5,862	2,464,387	65.00
66.00	06600 PHYSICAL THERAPY	1,510,397	0	1,510,397	0	1,510,397	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	1,903,458		1,903,458	0	1,903,458	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,999,191		3,999,191	0	3,999,191	73.00
74.00	07400 RENAL DIALYSIS	671,868		671,868	1,519	673,387	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
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)	28,914,202	0	28,914,202	154,334	29,068,536	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	28,914,202	0	28,914,202	154,334	29,068,536	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

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		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	30,059,042		30,059,042			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	821,529	0	821,529	0.422310	0.000000	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,203,225	0	1,203,225	0.482233	0.000000	54.00
60.00	06000 LABORATORY	8,364,802	0	8,364,802	0.109547	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	23,800,595	0	23,800,595	0.103297	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	5,203,894	0	5,203,894	0.290244	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,392,170	0	8,392,170	0.226814	0.000000	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21,506,324	0	21,506,324	0.185954	0.000000	73.00
74.00	07400 RENAL DIALYSIS	1,118,805	0	1,118,805	0.600523	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0	0.000000	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
100.00	10000 I&R SERVICES - NOT APPRVD. PRGM.	0	0	0			100.00
200.00	Subtotal (see instructions)	100,470,386	0	100,470,386			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	100,470,386	0	100,470,386			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet C Part I Date/Time Prepared: 1/20/2014 6:07 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
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	0.422310		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.482233		54.00
60.00	06000 LABORATORY	0.109547		60.00
65.00	06500 RESPIRATORY THERAPY	0.103543		65.00
66.00	06600 PHYSICAL THERAPY	0.290244		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	0.226814		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.185954		73.00
74.00	07400 RENAL DIALYSIS	0.601881		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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 262010

Period:
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To 08/31/2013

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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	16,527,253		16,527,253	146,953	16,674,206	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
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	346,940		346,940	0	346,940	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	580,235		580,235	0	580,235	54.00
60.00	06000 LABORATORY	916,335		916,335	0	916,335	60.00
65.00	06500 RESPIRATORY THERAPY	2,458,525	0	2,458,525	5,862	2,464,387	65.00
66.00	06600 PHYSICAL THERAPY	1,510,397	0	1,510,397	0	1,510,397	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	1,903,458		1,903,458	0	1,903,458	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,999,191		3,999,191	0	3,999,191	73.00
74.00	07400 RENAL DIALYSIS	671,868		671,868	1,519	673,387	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
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)	28,914,202	0	28,914,202	154,334	29,068,536	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	28,914,202	0	28,914,202	154,334	29,068,536	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

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		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				
	9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	30,059,042		30,059,042		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	821,529	0	821,529	0.422310	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,203,225	0	1,203,225	0.482233	54.00
60.00	06000	LABORATORY	8,364,802	0	8,364,802	0.109547	60.00
65.00	06500	RESPIRATORY THERAPY	23,800,595	0	23,800,595	0.103297	65.00
66.00	06600	PHYSICAL THERAPY	5,203,894	0	5,203,894	0.290244	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	8,392,170	0	8,392,170	0.226814	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,506,324	0	21,506,324	0.185954	73.00
74.00	07400	RENAL DIALYSIS	1,118,805	0	1,118,805	0.600523	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)	100,470,386	0	100,470,386		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	100,470,386	0	100,470,386		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet C Part I Date/Time Prepared: 1/20/2014 6:07 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
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: 262010		Period: From 09/01/2012 To 08/31/2013		Worksheet D Part I Date/Time Prepared: 1/20/2014 6:07 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)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,556,540	0	2,556,540	17,558	145.61	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)	2,556,540		2,556,540	17,558		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	9,170	1,335,244				
31.00	INTENSIVE CARE UNIT	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (Lines 30-199)	9,170	1,335,244				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet D Part II Date/Time Prepared: 1/20/2014 6:07 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	40,160	821,529	0.048884	601,735	29,415	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	76,392	1,203,225	0.063489	760,352	48,274	54.00
60.00	06000 LABORATORY	109,082	8,364,802	0.013041	4,687,683	61,132	60.00
65.00	06500 RESPIRATORY THERAPY	195,794	23,800,595	0.008226	11,206,121	92,182	65.00
66.00	06600 PHYSICAL THERAPY	114,430	5,203,894	0.021989	2,822,020	62,053	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	277,847	8,392,170	0.033108	4,375,161	144,853	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	373,020	21,506,324	0.017345	11,710,721	203,122	73.00
74.00	07400 RENAL DIALYSIS	74,545	1,118,805	0.066629	710,303	47,327	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
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)	1,261,270	70,411,344		36,874,096	688,358	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 262010		Period: From 09/01/2012 To 08/31/2013		Worksheet D Part III Date/Time Prepared: 1/20/2014 6:07 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	17,558	0.00	9,170	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)	17,558		9,170	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet D
Part IV
Date/Time Prepared:
1/20/2014 6:07 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	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet D
Part IV
Date/Time Prepared:
1/20/2014 6:07 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	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	821,529	0.000000	0.000000	601,735	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,203,225	0.000000	0.000000	760,352	54.00
60.00	06000 LABORATORY	0	8,364,802	0.000000	0.000000	4,687,683	60.00
65.00	06500 RESPIRATORY THERAPY	0	23,800,595	0.000000	0.000000	11,206,121	65.00
66.00	06600 PHYSICAL THERAPY	0	5,203,894	0.000000	0.000000	2,822,020	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	8,392,170	0.000000	0.000000	4,375,161	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	21,506,324	0.000000	0.000000	11,710,721	73.00
74.00	07400 RENAL DIALYSIS	0	1,118,805	0.000000	0.000000	710,303	74.00
OUTPATIENT SERVICE COST CENTERS							
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
OTHER REIMBURSABLE COST CENTERS							
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	70,411,344			36,874,096	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet D
Part IV
Date/Time Prepared:
1/20/2014 6:07 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XVIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
OTHER REIMBURSABLE COST CENTERS						
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	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet D Part V Date/Time Prepared: 1/20/2014 6:07 pm
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.422310	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.482233	0	5,610	0	54.00
60.00	06000	LABORATORY	0.109547	0	1,512	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.103297	0	24,157	0	65.00
66.00	06600	PHYSICAL THERAPY	0.290244	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.226814	0	403	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.185954	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.600523	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	98.00
200.00		Subtotal (see instructions)		0	31,682	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	31,682	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet D Part V Date/Time Prepared: 1/20/2014 6:07 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		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,705	0	54.00
60.00	06000 LABORATORY	166	0	60.00
65.00	06500 RESPIRATORY THERAPY	2,495	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	91	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00	Subtotal (see instructions)	5,457	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	5,457	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 1/20/2014 6:07 pm
Cost Center Description		PPS		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		17,558	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,558	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)		17,558	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)		9,170	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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)		16,674,206	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)		16,674,206	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		16,674,206	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		949.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,708,382	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)		8,708,382	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet D-1 Date/Time Prepared: 1/20/2014 6:07 pm
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 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)					6,711,218 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					15,419,600 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)					1,335,244 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					688,358 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,023,602 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					13,395,998 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: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet D-1
Date/Time Prepared:
1/20/2014 6:07 pm

Cost Center Description		Cost	Title XVIII		Hospital	
			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	2,556,540	16,674,206	0.153323	0	90.00
91.00	Nursing School cost	0	16,674,206	0.000000	0	91.00
92.00	Allied health cost	0	16,674,206	0.000000	0	92.00
93.00	All other Medical Education	0	16,674,206	0.000000	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 1/20/2014 6:07 pm
Cost Center Description				Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		17,558	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,558	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)		17,558	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,412	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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)		16,527,253	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)		16,527,253	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		16,527,253	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		941.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,270,391	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,270,391	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet D-1 Date/Time Prepared: 1/20/2014 6:07 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)
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00
42.00	Intensive Care Type Inpatient Hospital Units					42.00
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,270,391
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: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet D-1
Date/Time Prepared:
1/20/2014 6:07 pm

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
				Total Observation Bed Cost (from line 89)	Cost		
	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	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet D-2

Date/Time Prepared:
1/20/2014 6:07 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															
PART I - NOT IN APPROVED TEACHING PROGRAM																				
Hospital Inpatient Routine Services:																				
1.00 Total cost of services rendered	0.00	0				1.00														
2.00 ADULTS & PEDIATRICS	0.00	0	17,558	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															
PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)																				
Hospital Inpatient Routine Services:																				
29.00 ADULTS & PEDIATRICS	0	0	0	17,558	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														

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	
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)				
Hospital				
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

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS	Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet D-2 Date/Time Prepared: 1/20/2014 6:07 pm
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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				
PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00 Total cost of services rendered						1.00
Hospital Inpatient Routine Services:						
2.00 ADULTS & PEDIATRICS	9,170	2,412	0	0	0	2.00
3.00 INTENSIVE CARE UNIT	0	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	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	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	0	23.00
24.00 EMERGENCY	0	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	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		
PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)						
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: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet D-2

Date/Time Prepared:
1/20/2014 6:07 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		
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)					
Hospital					
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: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet D-3 Date/Time Prepared: 1/20/2014 6:07 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		15,648,275		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.422310	601,735	254,119	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.482233	760,352	366,667	54.00
60.00	06000 LABORATORY	0.109547	4,687,683	513,522	60.00
65.00	06500 RESPIRATORY THERAPY	0.103543	11,206,121	1,160,315	65.00
66.00	06600 PHYSICAL THERAPY	0.290244	2,822,020	819,074	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	0.226814	4,375,161	992,348	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.185954	11,710,721	2,177,655	73.00
74.00	07400 RENAL DIALYSIS	0.601881	710,303	427,518	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)		36,874,096	6,711,218	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		36,874,096		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet E Part B Date/Time Prepared: 1/20/2014 6:07 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,457	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,457	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		31,682	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)		31,682	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		31,682	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		26,225	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)		5,457	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		6,336	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	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)		-879	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)		-879	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		-879	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		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 (see instructions)		-879	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		-879	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
41.00	Interim payments		3,819	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-4,698	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet E-1
Part I
Date/Time Prepared:
1/20/2014 6:07 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		14,483,638		3,819	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	11/29/2012	208,000		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	11/27/2013	650,600		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)		-442,600		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)		14,041,038		3,819	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		376,821		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		4,698	6.02
7.00	Total Medicare program liability (see instructions)		14,417,859		-879	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet E-3 Part IV Date/Time Prepared: 1/20/2014 6:07 pm
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		13,971,259	1.00
2.00	Outlier Payments		1,095,716	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		15,066,975	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		0	5.00
6.00	Cost of teaching physicians		0	6.00
7.00	Subtotal (see instructions)		15,066,975	7.00
8.00	Primary payer payments		17,625	8.00
9.00	Subtotal (line 7 less line 8).		15,049,350	9.00
10.00	Deductibles		30,392	10.00
11.00	Subtotal (line 9 minus line 10)		15,018,958	11.00
12.00	Coinsurance		965,970	12.00
13.00	Subtotal (line 11 minus line 12)		14,052,988	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		695,724	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		487,007	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		493,898	16.00
17.00	Subtotal (sum of lines 13 and 15)		14,539,995	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)		14,539,995	22.00
22.01	Sequestration adjustment (see instructions)		122,136	22.01
23.00	Interim payments		14,041,038	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)		376,821	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
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: 262010	Period: From 09/01/2012 To 08/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 1/20/2014 6:07 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		2,270,391		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)		2,270,391	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)		2,270,391	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	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)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		2,270,391	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)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		2,270,391	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	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)		0	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)		0	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)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	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: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet G

Date/Time Prepared:
1/20/2014 6:07 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,126,116	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	6,035,577	0	0	0	4.00
5.00	Other receivable	1,123	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-620,679	0	0	0	6.00
7.00	Inventory	276,541	0	0	0	7.00
8.00	Prepaid expenses	0	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)	6,818,678	0	0	0	11.00
FIXED ASSETS						
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	1,210,392	0	0	0	17.00
18.00	Accumulated depreciation	-1,108,149	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	4,867,314	0	0	0	23.00
24.00	Accumulated depreciation	-3,901,777	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)	1,067,780	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	107,123	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	107,123	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	7,993,581	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	938,526	0	0	0	37.00
38.00	Salaries, wages, and fees payable	793,116	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	264,583	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,996,225	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-23,912,994	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-23,912,994	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-21,916,769	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	29,910,350				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)	29,910,350	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	7,993,581	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet G-1

Date/Time Prepared:
1/20/2014 6:07 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		29,279,392		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		630,961			2.00
3.00	Total (sum of line 1 and line 2)		29,910,353		0	3.00
4.00	Additions (credit adjustments)	0		0		4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	-3		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)		-3		0	10.00
11.00	Subtotal (line 3 plus line 10)		29,910,350		0	11.00
12.00	Deductions (debit adjustments)	0		0		12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		29,910,350		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: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
1/20/2014 6:07 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	29,150,092		29,150,092	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)	29,150,092		29,150,092	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	908,950		908,950	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)	908,950		908,950	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	30,059,042		30,059,042	17.00
18.00	Ancillary services	70,524,525	0	70,524,525	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)	100,583,567	0	100,583,567	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		30,055,803		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)		30,055,803		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 262010

Period:
From 09/01/2012
To 08/31/2013

Worksheet G-3

Date/Time Prepared:
1/20/2014 6:07 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	100,583,567	1.00
2.00	Less contractual allowances and discounts on patients' accounts	69,947,211	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,636,356	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	30,055,803	4.00
5.00	Net income from service to patients (line 3 minus line 4)	580,553	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	2,727	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	6,625	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	2,886	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	302	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	37,868	24.00
25.00	Total other income (sum of lines 6-24)	50,408	25.00
26.00	Total (line 5 plus line 25)	630,961	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)	630,961	29.00