

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: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet S Parts I-III Date/Time Prepared: 1/26/2015 10:55 am
--	----------------------	---	---

<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 1/26/2015 Time: 10:55 am	
	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.		
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 Sycamore ( 142006 ) for the cost reporting period beginning 09/01/2013 and ending 08/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-2,206	-5,179	0	1,339,112	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00 Total	0	-2,206	-5,179	0	1,339,112	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142006		Period: From 09/01/2013 To 08/31/2014		Worksheet S-2 Part I Date/Time Prepared: 1/26/2015 10:54 am						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 225 Edward Street	PO Box:							1.00			
2.00	City: Sycamore	State: IL		Zip Code: 60178		County: DeKalb			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 Sycamore		142006	16974	2	01/01/1988	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)						09/01/2013	08/31/2014		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		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)									22.01		
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet S-2 Part I Date/Time Prepared: 1/26/2015 10:54 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 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, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet S-2 Part I Date/Time Prepared: 1/26/2015 10:54 am		
	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		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
<u>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</u>						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142006		Period: From 09/01/2013 To 08/31/2014		Worksheet S-2 Part I Date/Time Prepared: 1/26/2015 10:54 am	
	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
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. 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
<b>Inpatient Rehabilitation Facility PPS</b>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, 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		
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					Y	80.00
<b>TEFRA Providers</b>							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						106.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet S-2 Part I Date/Time Prepared: 1/26/2015 10:54 am	
		V 1.00	XIX 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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	2.00 3.00
<b>Miscellaneous Cost Reporting Information</b>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0
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 1.00	Losses 2.00	Insurance 3.00
118.01	List amounts of malpractice premiums and paid losses:		16,276	0	96,548
			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 high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		189003

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet S-2 Part I Date/Time Prepared: 1/26/2015 10:54 am			
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			
165.00	Multi campus 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: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet S-2 Part II Date/Time Prepared: 1/26/2015 10:54 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/31/2015	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		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	11/30/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet S-2  
Part II  
Date/Time Prepared:  
1/26/2015 10:54 am

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
1.00					
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
Y/N					Date
1.00					2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2014	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
1.00					2.00
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN	HOURIGAN		41.00
42.00	Enter the employer/company name of the cost report preparer.	KINDRED HEALTHCARE INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5025967856	Daniel.Hourigan@kindred.com		43.00

		Part B		
		Date		
		4.00		
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	11/30/2014		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/26/2015 10:54 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	69	25,185	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)		69	25,185	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)		69	25,185	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)		69				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/26/2015 10:54 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,384	4,459	14,434			1.00
2.00 HMO and other (see instructions)	740	582				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,384	4,459	14,434			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	6,384	4,459	14,434	0.00	132.20	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	132.20	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	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	25					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/26/2015 10:54 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	240	146	518	1.00
2.00 HMO and other (see instructions)			27	25		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	240	146	518	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
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet S-3  
Part II  
Date/Time Prepared:  
1/26/2015 10:54 am

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	7,152,719	0	7,152,719	275,177.80	25.99
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	47,477	47,477	1,281.00	37.06
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor: Direct Patient Care		2,114,983	0	2,114,983	37,047.00	57.09
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		698,735	0	698,735	8,045.00	86.85
14.00	Home office salaries & wage-related costs		730,339	0	730,339	16,230.00	45.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		1,257,782	0	1,257,782		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		8,404	0	8,404		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	45,299	0	45,299	1,211.80	37.38
27.00	Administrative & General	5.00	1,027,400	0	1,027,400	30,281.00	33.93
28.00	Administrative & General under contract (see inst.)		3,609	0	3,609	61.00	59.16
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	196,642	0	196,642	16,939.00	11.61
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	260,350	0	260,350	16,667.00	15.62
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	550,512	0	550,512	14,364.00	38.33
39.00	Central Services and Supply	14.00	93,178	0	93,178	4,356.00	21.39
40.00	Pharmacy	15.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet S-3  
Part II  
Date/Time Prepared:  
1/26/2015 10:54 am

	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	
41.00	Medical Records & Medical Records Library	16.00 247,491	0	247,491	9,342.00	26.49	41.00
42.00	Social Service	17.00 306,048	-47,477	258,571	6,978.00	37.06	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet S-3  
Part III  
Date/Time Prepared:  
1/26/2015 10:54 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	7,156,328	0	7,156,328	275,238.80	26.00	1.00
2.00	Excluded area salaries (see instructions)	0	47,477	47,477	1,281.00	37.06	2.00
3.00	Subtotal salaries (line 1 minus line 2)	7,156,328	-47,477	7,108,851	273,957.80	25.95	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,544,057	0	3,544,057	61,322.00	57.79	4.00
5.00	Subtotal wage-related costs (see inst.)	1,257,782	0	1,257,782	0.00	17.69	5.00
6.00	Total (sum of lines 3 thru 5)	11,958,167	-47,477	11,910,690	335,279.80	35.52	6.00
7.00	Total overhead cost (see instructions)	2,730,529	-47,477	2,683,052	100,199.80	26.78	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet S-3 Part IV Date/Time Prepared: 1/26/2015 10:54 am
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			540 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)			341,496 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			-4,958 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			4,813 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)			17,472 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			235,846 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			512,010 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			100,095 20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			50,467 23.00
24.00	<b>Total Wage Related cost (Sum of lines 1 -23)</b>			<b>1,257,781 24.00</b>
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet A  
Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		4,109,795	4,109,795	122,671	4,232,466	1.00
2.00	00200		317,048	317,048	60,873	377,921	2.00
3.00	00300		183,544	183,544	-183,544	0	3.00
4.00	00400	45,299	1,339,747	1,385,046	0	1,385,046	4.00
5.00	00500	1,027,400	3,714,307	4,741,707	0	4,741,707	5.00
7.00	00700	0	701,843	701,843	0	701,843	7.00
8.00	00800	0	130,182	130,182	0	130,182	8.00
9.00	00900	196,642	51,212	247,854	0	247,854	9.00
10.00	01000	260,350	165,177	425,527	0	425,527	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	550,512	4,572	555,084	0	555,084	13.00
14.00	01400	93,178	24,833	118,011	0	118,011	14.00
15.00	01500	0	687,579	687,579	0	687,579	15.00
16.00	01600	247,491	140,665	388,156	0	388,156	16.00
17.00	01700	306,048	40,249	346,297	-53,721	292,576	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	3,430,228	1,051,555	4,481,783	3,140	4,484,923	30.00
31.00	03100	0	3,140	3,140	-3,140	0	31.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	58,275	102,292	160,567	0	160,567	50.00
54.00	05400	73,590	161,443	235,033	0	235,033	54.00
60.00	06000	42,947	433,470	476,417	0	476,417	60.00
65.00	06500	820,759	73,401	894,160	0	894,160	65.00
66.00	06600	0	1,139,884	1,139,884	0	1,139,884	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	735,552	735,552	0	735,552	71.00
73.00	07300	0	985,647	985,647	0	985,647	73.00
74.00	07400	0	315,632	315,632	0	315,632	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	09500	0	0	0	0	0	98.00
100.00	10000	0	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		7,152,719	16,612,769	23,765,488	-53,721	23,711,767	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	53,721	53,721	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		7,152,719	16,612,769	23,765,488	0	23,765,488	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet A  
Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-11,498	4,220,968	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	7,836	385,757	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,847	1,383,199	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-814,313	3,927,394	5.00
7.00	00700	OPERATION OF PLANT	-1,005	700,838	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	130,182	8.00
9.00	00900	HOUSEKEEPING	0	247,854	9.00
10.00	01000	DIETARY	-26,499	399,028	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	555,084	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	118,011	14.00
15.00	01500	PHARMACY	0	687,579	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,812	384,344	16.00
17.00	01700	SOCIAL SERVICE	0	292,576	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	32,875	4,517,798	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	160,567	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	235,033	54.00
60.00	06000	LABORATORY	-975	475,442	60.00
65.00	06500	RESPIRATORY THERAPY	0	894,160	65.00
66.00	06600	PHYSICAL THERAPY	-61,996	1,077,888	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	735,552	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	985,647	73.00
74.00	07400	RENAL DIALYSIS	0	315,632	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-881,234	22,830,533	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	53,721	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)	-881,234	22,884,254	200.00

RECLASSIFICATIONS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet A-6

Date/Time Prepared:  
1/26/2015 10:54 am

		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	47,477	6,244	1.00
	TOTALS			47,477	6,244	
C - RCL ICU EXPENSE						
1.00	ADULTS & PEDIATRICS		30.00	0	3,140	1.00
	TOTALS			0	3,140	
500.00	Grand Total: Increases			47,477	9,384	500.00

RECLASSIFICATIONS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet A-6

Date/Time Prepared:  
1/26/2015 10:54 am

		Decreases						
		Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
		6.00	7.00	8.00	9.00	10.00		
A - RECLASS NON ALLOWABLE CASE MANAGER								
1.00	SOCIAL SERVICE		17.00	47,477	6,244	0		1.00
	TOTALS			47,477	6,244			
C - RCL ICU EXPENSE								
1.00	INTENSIVE CARE UNIT		31.00	0	3,140	0		1.00
	TOTALS			0	3,140			
500.00	Grand Total: Decreases			47,477	9,384			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet A-7  
Part I  
Date/Time Prepared:  
1/26/2015 10:54 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	0	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	7,911,446	14,606	0	14,606	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	3,782,405	161,361	0	161,361	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	11,693,851	175,967	0	175,967	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	11,693,851	175,967	0	175,967	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	7,926,052	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	3,933,162	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	11,859,214	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	11,859,214	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet A-7  
Part II  
Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	132,855	3,976,940	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	166,272	150,776	0	0	0	2.00
3.00	Total (sum of lines 1-2)	299,127	4,127,716	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	4,109,795				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	317,048				2.00
3.00	Total (sum of lines 1-2)	0	4,426,843				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet A-7  
Part III  
Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	7,926,052	0	7,926,052	0.668345	18,534	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,933,162	0	3,933,162	0.331655	9,197	2.00
3.00	Total (sum of lines 1-2)	11,859,214	0	11,859,214	1.000000	27,731	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	104,137	0	122,671	131,022	3,976,940	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	51,676	0	60,873	174,108	150,776	2.00
3.00	Total (sum of lines 1-2)	155,813	0	183,544	305,130	4,127,716	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	8,869	104,137	0	4,220,968	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,197	51,676	0	385,757	2.00
3.00	Total (sum of lines 1-2)	0	18,066	155,813	0	4,606,725	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet A-8

Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			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	-1,970		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	-12,974		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-1,005		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	-7,280				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	-155,433				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-26,499		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	-3,812		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00			0		0.00	0	33.00
33.01 MISCELLANEOUS INCOME	B	-39,089		ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet A-8

Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
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	9,346	ADMINISTRATIVE & GENERAL		5.00	0 33.05
33.06		0			0.00	0 33.06
33.07	PROFESSIONAL FEES - CAPITAL PROJECT	-26,441	ADMINISTRATIVE & GENERAL		5.00	0 33.07
33.08	MEDICARE BAD DEBT - PART A	-333,400	ADMINISTRATIVE & GENERAL		5.00	0 33.08
33.09		0			0.00	0 33.09
33.10	OTHER MEDICARE NON ALLOWABLE	-20,687	ADMINISTRATIVE & GENERAL		5.00	0 33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	-1,696	ADMINISTRATIVE & GENERAL		5.00	0 33.11
33.12	OTHER OPERATING - PUBLIC RELATIONS	-1,023	ADMINISTRATIVE & GENERAL		5.00	0 33.12
33.13	OTHER OPERATING - MARKETING	-11,879	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	OTHER OPER - LITIGATION SETTLEMENT	-140,000	ADMINISTRATIVE & GENERAL		5.00	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	-11,000	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	-11,573	ADMINISTRATIVE & GENERAL		5.00	0 33.23
33.24		0			0.00	0 33.24
33.25		0			0.00	0 33.25
33.26		0			0.00	0 33.26
33.27		0			0.00	0 33.27
33.28	AGGREGATE CAPITAL EROSION	-5,691	ADMINISTRATIVE & GENERAL		5.00	0 33.28
33.29	CABLE TV AND SATELLITE	-11,382	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	-76,451	ADMINISTRATIVE & GENERAL		5.00	0 33.32
33.33		0			0.00	0 33.33
33.34	MALPRACTICE TAIL LIABILITY	25,521	ADMINISTRATIVE & GENERAL		5.00	0 33.34
33.35	AGGREGATE CAP PYMT-NONALLOWABLE	7,270	ADMINISTRATIVE & GENERAL		5.00	0 33.35
33.36		0			0.00	0 33.36
33.37	PHYSICIAN BILLING COLLECTION FEES	-415	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	-3,952	CAP REL COSTS-BLDG & FIXT		1.00	9 34.00
34.01	MEDICARE VS BOOK MOV EQUIP	-90,491	CAP REL COSTS-MVBLE EQUIP		2.00	9 34.01
34.02	ASSET ADD-ON BLDG	2,119	CAP REL COSTS-BLDG & FIXT		1.00	9 34.02
34.03	ASSET ADD-ON MOV EQUIP	98,327	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	-10,161	ADMINISTRATIVE & GENERAL		5.00	0 34.06
34.07		0			0.00	0 34.07
34.08	BUSINESS INTERRUPTION INS PREMIUM	-9,665	CAP REL COSTS-BLDG & FIXT		1.00	12 34.08
34.09		0			0.00	0 34.09
34.10		0			0.00	0 34.10
34.11		0			0.00	0 34.11
34.12		0			0.00	0 34.12
34.13		0			0.00	0 34.13
34.14		0			0.00	0 34.14
34.15		0			0.00	0 34.15
34.16		0			0.00	0 34.16
34.17		0			0.00	0 34.17
34.18		0			0.00	0 34.18
34.19		0			0.00	0 34.19
34.20		0			0.00	0 34.20
34.21		0			0.00	0 34.21

ADJUSTMENTS TO EXPENSES

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet A-8

Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
34.22 DISTRICT OFFICE SALES AND MARKETING	A	-18,990	ADMINISTRATIVE & GENERAL		5.00	0	34.22
34.23 DISTRICT OFC SALES AND MKT BENEFITS	A	-1,847	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	-39,180	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		0			0.00	0	35.09
35.10		0			0.00	0	35.10
35.11 PHYSICIAN FEE ADJUSTMENT	A	40,155	ADULTS & PEDIATRICS		30.00	0	35.11
35.12		0			0.00	0	35.12
35.13		0			0.00	0	35.13
35.14		0			0.00	0	35.14
35.15		0			0.00	0	35.15
35.16 PHYSICIAN FEE ADJUSTMENT	A	-975	LABORATORY		60.00	0	35.16
35.17		0			0.00	0	35.17
35.18		0			0.00	0	35.18
35.19		0			0.00	0	35.19
35.20		0			0.00	0	35.20
35.21		0			0.00	0	35.21
35.22		0			0.00	0	35.22
35.23		0			0.00	0	35.23
35.24		0			0.00	0	35.24
35.25		0			0.00	0	35.25
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-881,234					50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 142006

Period: From 09/01/2013 To 08/31/2014

Worksheet A-8-1

Date/Time Prepared: 1/26/2015 10:54 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	1,223,564	1,317,001 1.00
2.00	4.00	EMPLOYEE BENEFITS	Workers Comp Premium	239,607	239,607 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	105,312	105,312 3.00
4.00	0.00			0	0 4.00
4.01	66.00	PHYSICAL THERAPY	Therapy Services	1,076,327	1,138,323 4.01
4.02	60.00	LABORATORY	Hospital Related services	62,806	62,806 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			2,707,616	2,863,049 5.00

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

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

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

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

6.00	B	Kindred Inc-Hos	100.00	Admin & Gen	100.00	6.00
7.00	B	Kindred Inc-Hos	100.00	Cornerstone	100.00	7.00
8.00	B	Kindred Inc-Hos	100.00	Cornerstone	100.00	8.00
9.00			0.00		0.00	9.00
10.00	B	Kindred Inc-Hos	100.00	RehabCare	100.00	10.00
10.01	B	Kindred Inc-Hos	100.00	KH - Chicago North	100.00	10.01
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: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet A-8-1

Date/Time Prepared:  
1/26/2015 10:54 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-93,437	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	-61,996	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	-155,433			5.00

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

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

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

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

6.00	HomeOffice Cost		6.00
7.00	Worker Comp Ins		7.00
8.00	Liability Insur		8.00
9.00			9.00
10.00	Therapy Svcs		10.00
10.01	Laboratory		10.01
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: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet A-8-2

Date/Time Prepared:  
1/26/2015 10:54 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	30.00	DR. B	658,580	0	658,580	177,200	7,748	2.00
3.00	30.00	DR. C	5,655	0	5,655	177,200	39	3.00
4.00	30.00	DR. D	15,900	0	15,900	177,200	133	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	30.00	DR. F	975	0	975	177,200	7	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			681,110	0	681,110		7,927	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	0.00		0	0	0	0	0	1.00
2.00	30.00	DR. B	660,070	33,004	0	0	0	2.00
3.00	30.00	DR. C	3,323	166	0	0	0	3.00
4.00	30.00	DR. D	11,331	567	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	30.00	DR. F	596	30	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			675,320	33,767	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	0.00		0	0	0	0	1.00
2.00	30.00	DR. B	0	660,070	0	0	2.00
3.00	30.00	DR. C	0	3,323	2,332	2,332	3.00
4.00	30.00	DR. D	0	11,331	4,569	4,569	4.00
5.00	0.00		0	0	0	0	5.00
6.00	30.00	DR. F	0	596	379	379	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	675,320	7,280	7,280	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet B  
Part I  
Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,220,968	4,220,968			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	385,757		385,757		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,383,199	61,340	5,606	1,450,145	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,927,394	703,717	64,313	209,624	4,905,048
7.00 00700	OPERATION OF PLANT	700,838	568,296	51,937	0	1,321,071
8.00 00800	LAUNDRY & LINEN SERVICE	130,182	71,101	6,498	0	207,781
9.00 00900	HOUSEKEEPING	247,854	60,724	5,550	40,121	354,249
10.00 01000	DIETARY	399,028	404,003	36,922	53,120	893,073
11.00 01100	CAFETERIA	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	555,084	38,736	3,540	112,323	709,683
14.00 01400	CENTRAL SERVICES & SUPPLY	118,011	423,319	38,687	19,011	599,028
15.00 01500	PHARMACY	687,579	103,980	9,503	0	801,062
16.00 01600	MEDICAL RECORDS & LIBRARY	384,344	60,518	5,531	50,496	500,889
17.00 01700	SOCIAL SERVICE	292,576	33,290	3,042	52,757	381,665
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	4,517,798	1,360,789	124,364	699,876	6,702,827
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	160,567	0	0	11,890	172,457
54.00 05400	RADIOLOGY-DIAGNOSTIC	235,033	43,051	3,934	15,015	297,033
60.00 06000	LABORATORY	475,442	91,240	8,338	8,763	583,783
65.00 06500	RESPIRATORY THERAPY	894,160	39,147	3,578	167,462	1,104,347
66.00 06600	PHYSICAL THERAPY	1,077,888	157,717	14,414	0	1,250,019
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	735,552	0	0	0	735,552
73.00 07300	DRUGS CHARGED TO PATIENTS	985,647	0	0	0	985,647
74.00 07400	RENAL DIALYSIS	315,632	0	0	0	315,632
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
98.00 09500	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
100.00 10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,830,533	4,220,968	385,757	1,440,458	22,820,846
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	NONALLOWABLE CASE MANAGER	53,721	0	0	9,687	63,408
194.01 07951	IDLE SPACE	0	0	0	0	0
194.02 07952	REGIONAL OFFICE	0	0	0	0	0
194.03 07953	DISTRICT OFFICE	0	0	0	0	0
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05 07955	REG NURSG OFFICE	0	0	0	0	0
194.06 07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0
194.07 07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09 07958	VISITOR MEALS	0	0	0	0	0
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	22,884,254	4,220,968	385,757	1,450,145	22,884,254

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet B  
Part I  
Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,905,048				5.00
7.00	00700	OPERATION OF PLANT	360,412	1,681,483			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56,686	41,403	305,870		8.00
9.00	00900	HOUSEKEEPING	96,646	35,360	0	486,255	9.00
10.00	01000	DIETARY	243,646	235,254	0	71,286	1,443,259
11.00	01100	CAFETERIA	0	0	0	0	695,771
13.00	01300	NURSING ADMINISTRATION	193,614	22,556	0	6,835	0
14.00	01400	CENTRAL SERVICES & SUPPLY	163,426	246,503	0	74,694	0
15.00	01500	PHARMACY	218,544	60,549	0	18,347	0
16.00	01600	MEDICAL RECORDS & LIBRARY	136,652	35,240	0	10,678	0
17.00	01700	SOCIAL SERVICE	104,125	19,385	0	5,874	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,828,648	792,398	305,870	240,110	742,424
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	47,049	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,036	25,069	0	7,596	0
60.00	06000	LABORATORY	159,267	53,130	0	16,099	0
65.00	06500	RESPIRATORY THERAPY	301,286	22,796	0	6,907	0
66.00	06600	PHYSICAL THERAPY	341,028	91,840	0	27,829	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	200,672	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	268,902	0	0	0	0
74.00	07400	RENAL DIALYSIS	86,110	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,887,749	1,681,483	305,870	486,255	1,438,195
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	17,299	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	5,064
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)	4,905,048	1,681,483	305,870	486,255	1,443,259

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142006

Period: From 09/01/2013 To 08/31/2014

Worksheet B Part I Date/Time Prepared: 1/26/2015 10:54 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	695,771					11.00
13.00	01300	47,749	980,437				13.00
14.00	01400	13,643	0	1,097,294			14.00
15.00	01500	0	0	16,550	1,115,052		15.00
16.00	01600	34,106	0	2,910	0	720,475	16.00
17.00	01700	27,285	0	253	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	457,027	966,019	53,746	30,935	250,895	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	6,821	14,418	0	0	5,917	50.00
54.00	05400	6,821	0	856	0	16,664	54.00
60.00	06000	6,821	0	3,182	0	58,895	60.00
65.00	06500	95,498	0	3,498	0	107,296	65.00
66.00	06600	0	0	923	0	41,056	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	1,015,353	0	55,972	71.00
73.00	07300	0	0	0	1,084,117	173,172	73.00
74.00	07400	0	0	23	0	10,608	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	09500	0	0	0	0	0	98.00
100.00	10000	0	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		695,771	980,437	1,097,294	1,115,052	720,475	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		695,771	980,437	1,097,294	1,115,052	720,475	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet B  
Part I  
Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400					14.00
15.00	01500					15.00
16.00	01600					16.00
17.00	01700	538,587				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	538,587	12,909,486	0	12,909,486	30.00
31.00	03100	0	0	0	0	31.00
44.00	04400	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	0	246,662	0	246,662	50.00
54.00	05400	0	435,075	0	435,075	54.00
60.00	06000	0	881,177	0	881,177	60.00
65.00	06500	0	1,641,628	0	1,641,628	65.00
66.00	06600	0	1,752,695	0	1,752,695	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
71.00	07100	0	2,007,549	0	2,007,549	71.00
73.00	07300	0	2,511,838	0	2,511,838	73.00
74.00	07400	0	412,373	0	412,373	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	0	0	0	0	90.00
91.00	09100	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	0	0	0	0	95.00
98.00	09500	0	0	0	0	98.00
100.00	10000	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		538,587	22,798,483	0	22,798,483	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
194.00	07950	0	80,707	0	80,707	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	5,064	0	5,064	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		538,587	22,884,254	0	22,884,254	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet B  
Part II  
Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	61,340	5,606	66,946	66,946 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	146,192	703,717	64,313	914,222	9,677 5.00
7.00 00700	OPERATION OF PLANT	0	568,296	51,937	620,233	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	71,101	6,498	77,599	0 8.00
9.00 00900	HOUSEKEEPING	0	60,724	5,550	66,274	1,852 9.00
10.00 01000	DIETARY	0	404,003	36,922	440,925	2,452 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	0	38,736	3,540	42,276	5,185 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	423,319	38,687	462,006	878 14.00
15.00 01500	PHARMACY	0	103,980	9,503	113,483	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	60,518	5,531	66,049	2,331 16.00
17.00 01700	SOCIAL SERVICE	0	33,290	3,042	36,332	2,435 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	1,360,789	124,364	1,485,153	32,311 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	549 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	43,051	3,934	46,985	693 54.00
60.00 06000	LABORATORY	0	91,240	8,338	99,578	405 60.00
65.00 06500	RESPIRATORY THERAPY	0	39,147	3,578	42,725	7,731 65.00
66.00 06600	PHYSICAL THERAPY	0	157,717	14,414	172,131	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	0	0	0	0	0 91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
98.00 09500	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
100.00 10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0 100.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	146,192	4,220,968	385,757	4,752,917	66,499 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00 07950	NONALLOWABLE CASE MANAGER	0	0	0	0	447 194.00
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				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	146,192	4,220,968	385,757	4,752,917	66,946 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet B Part II Date/Time Prepared: 1/26/2015 10:54 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	923,899				5.00	
7.00	00700	OPERATION OF PLANT	67,886	688,119			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	10,677	16,943	105,219		8.00	
9.00	00900	HOUSEKEEPING	18,204	14,470	0	100,800	9.00	
10.00	01000	DIETARY	45,892	96,274	0	14,777	10.00	
11.00	01100	CAFETERIA	0	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	36,468	9,231	0	1,417	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	30,782	100,877	0	15,484	14.00	
15.00	01500	PHARMACY	41,164	24,779	0	3,803	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	25,739	14,422	0	2,214	16.00	
17.00	01700	SOCIAL SERVICE	19,613	7,933	0	1,218	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	344,441	324,276	105,219	49,774	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	8,862	0	0	0	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,264	10,259	0	1,575	54.00	
60.00	06000	LABORATORY	29,999	21,742	0	3,337	60.00	
65.00	06500	RESPIRATORY THERAPY	56,749	9,329	0	1,432	65.00	
66.00	06600	PHYSICAL THERAPY	64,235	37,584	0	5,769	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	37,798	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	50,649	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	16,219	0	0	0	74.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	91.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00	
98.00	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	
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	920,641	688,119	105,219	100,800	598,214	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00	
194.00	07950	NONALLOWABLE CASE MANAGER	3,258	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					200.00	
201.00		Negative Cost Centers	0	0	0	0	201.00	
202.00		TOTAL (sum lines 118-201)	923,899	688,119	105,219	100,800	600,320	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142006		Period: From 09/01/2013 To 08/31/2014		Worksheet B Part II Date/Time Prepared: 1/26/2015 10:54 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	289,404					11.00
13.00	01300	19,861	114,438				13.00
14.00	01400	5,675	0	615,702			14.00
15.00	01500	0	0	9,286	192,515		15.00
16.00	01600	14,186	0	1,633	0	126,574	16.00
17.00	01700	11,349	0	142	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	190,100	112,755	30,157	5,341	44,064	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	2,837	1,683	0	0	1,040	50.00
54.00	05400	2,837	0	480	0	2,928	54.00
60.00	06000	2,837	0	1,785	0	10,348	60.00
65.00	06500	39,722	0	1,963	0	18,853	65.00
66.00	06600	0	0	518	0	7,214	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	569,725	0	9,835	71.00
73.00	07300	0	0	0	187,174	30,428	73.00
74.00	07400	0	0	13	0	1,864	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	05950	0	0	0	0	0	98.00
100.00	10000	0	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		289,404	114,438	615,702	192,515	126,574	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		289,404	114,438	615,702	192,515	126,574	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet B  
Part II  
Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400					14.00
15.00	01500					15.00
16.00	01600					16.00
17.00	01700	79,022				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	79,022	3,111,423	0	3,111,423	30.00
31.00	03100	0	0	0	0	31.00
44.00	04400	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	0	14,971	0	14,971	50.00
54.00	05400	0	81,021	0	81,021	54.00
60.00	06000	0	170,031	0	170,031	60.00
65.00	06500	0	178,504	0	178,504	65.00
66.00	06600	0	287,451	0	287,451	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
71.00	07100	0	617,358	0	617,358	71.00
73.00	07300	0	268,251	0	268,251	73.00
74.00	07400	0	18,096	0	18,096	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	0	0	0	0	90.00
91.00	09100	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	0	0	0	0	95.00
98.00	05950	0	0	0	0	98.00
100.00	10000	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		79,022	4,747,106	0	4,747,106	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
194.00	07950	0	3,705	0	3,705	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	2,106	0	2,106	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		79,022	4,752,917	0	4,752,917	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet B-1  
Date/Time Prepared:  
1/26/2015 10:54 am

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				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	41,081				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		41,081			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	597	597	7,107,420		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,849	6,849	1,027,400	-4,905,048	5.00
7.00 00700	OPERATION OF PLANT	5,531	5,531	0	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	692	692	0	0	8.00
9.00 00900	HOUSEKEEPING	591	591	196,642	0	9.00
10.00 01000	DIETARY	3,932	3,932	260,350	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	377	377	550,512	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	4,120	4,120	93,178	0	14.00
15.00 01500	PHARMACY	1,012	1,012	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	589	589	247,491	0	16.00
17.00 01700	SOCIAL SERVICE	324	324	258,571	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	13,244	13,244	3,430,228	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	58,275	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	419	419	73,590	0	54.00
60.00 06000	LABORATORY	888	888	42,947	0	60.00
65.00 06500	RESPIRATORY THERAPY	381	381	820,759	0	65.00
66.00 06600	PHYSICAL THERAPY	1,535	1,535	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09500	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
100.00 10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	41,081	41,081	7,059,943	-4,905,048	17,915,798
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CASE MANAGER	0	0	47,477	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)	4,220,968	385,757	1,450,145		4,905,048
203.00	Unit cost multiplier (Wkst. B, Part I)	102.747450	9.390156	0.204033		0.272818
204.00	Cost to be allocated (per Wkst. B, Part II)			66,946		923,899
205.00	Unit cost multiplier (Wkst. B, Part II)			0.009419		0.051387

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet B-1

Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	28,104				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	692	14,434			8.00
9.00	00900	HOUSEKEEPING	591	0	26,821		9.00
10.00	01000	DIETARY	3,932	0	3,932	52,157	10.00
11.00	01100	CAFETERIA	0	0	0	25,144	11.00
13.00	01300	NURSING ADMINISTRATION	377	0	377	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,120	0	4,120	0	14.00
15.00	01500	PHARMACY	1,012	0	1,012	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	589	0	589	0	16.00
17.00	01700	SOCIAL SERVICE	324	0	324	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	13,244	14,434	13,244	26,830	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	419	0	419	0	54.00
60.00	06000	LABORATORY	888	0	888	0	60.00
65.00	06500	RESPIRATORY THERAPY	381	0	381	0	65.00
66.00	06600	PHYSICAL THERAPY	1,535	0	1,535	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09800	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,104	14,434	26,821	51,974	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	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	183	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)	1,681,483	305,870	486,255	1,443,259	695,771
203.00		Unit cost multiplier (Wkst. B, Part I)	59.830736	21.190938	18.129637	27.671434	6,821.284314
204.00		Cost to be allocated (per Wkst. B, Part II)	688,119	105,219	100,800	600,320	289,404
205.00		Unit cost multiplier (Wkst. B, Part II)	24.484735	7.289663	3.758249	11.509864	2,837.294118

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet B-1

Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description		NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	68					13.00
14.00	01400	0	794,912				14.00
15.00	01500	0	11,989	1,013,772			15.00
16.00	01600	0	2,108	0	71,843,429		16.00
17.00	01700	0	183	0	0	14,434	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	67	38,935	28,125	25,016,428	14,434	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1	0	0	590,070	0	50.00
54.00	05400	0	620	0	1,661,779	0	54.00
60.00	06000	0	2,305	0	5,873,089	0	60.00
65.00	06500	0	2,534	0	10,699,686	0	65.00
66.00	06600	0	669	0	4,094,157	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	735,552	0	5,581,587	0	71.00
73.00	07300	0	0	985,647	17,268,798	0	73.00
74.00	07400	0	17	0	1,057,835	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	09800	0	0	0	0	0	98.00
100.00	10000	0	0	0	0	0	100.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		68	794,912	1,013,772	71,843,429	14,434	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00							201.00
202.00		980,437	1,097,294	1,115,052	720,475	538,587	202.00
203.00		14,418.191176	1.380397	1.099904	0.010028	37.313773	203.00
204.00		114,438	615,702	192,515	126,574	79,022	204.00
205.00		1,682.911765	0.774554	0.189900	0.001762	5.474712	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet C  
Part I  
Date/Time Prepared:  
1/26/2015 10:54 am

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	12,909,486		12,909,486	7,280	12,916,766	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	246,662		246,662	0	246,662	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	435,075		435,075	0	435,075	54.00
60.00	06000 LABORATORY	881,177		881,177	0	881,177	60.00
65.00	06500 RESPIRATORY THERAPY	1,641,628	0	1,641,628	0	1,641,628	65.00
66.00	06600 PHYSICAL THERAPY	1,752,695	0	1,752,695	0	1,752,695	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	2,007,549		2,007,549	0	2,007,549	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,511,838		2,511,838	0	2,511,838	73.00
74.00	07400 RENAL DIALYSIS	412,373		412,373	0	412,373	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
100.00	10000 I&R SERVICES - NOT APPRVD. PRGM.	0		0	0	0	100.00
200.00	Subtotal (see instructions)	22,798,483	0	22,798,483	7,280	22,805,763	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	22,798,483	0	22,798,483	7,280	22,805,763	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet C  
Part I  
Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	25,016,428		25,016,428		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	590,070	0	590,070	0.418022	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,661,779	0	1,661,779	0.261813	54.00
60.00	06000	LABORATORY	5,873,089	0	5,873,089	0.150036	60.00
65.00	06500	RESPIRATORY THERAPY	10,699,686	0	10,699,686	0.153428	65.00
66.00	06600	PHYSICAL THERAPY	4,094,157	0	4,094,157	0.428097	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,581,587	0	5,581,587	0.359674	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,268,798	0	17,268,798	0.145455	73.00
74.00	07400	RENAL DIALYSIS	1,057,835	0	1,057,835	0.389827	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)	71,843,429	0	71,843,429		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	71,843,429	0	71,843,429		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet C Part I Date/Time Prepared: 1/26/2015 10:54 am
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	0.418022		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.261813		54.00
60.00	06000 LABORATORY	0.150036		60.00
65.00	06500 RESPIRATORY THERAPY	0.153428		65.00
66.00	06600 PHYSICAL THERAPY	0.428097		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	0.359674		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.145455		73.00
74.00	07400 RENAL DIALYSIS	0.389827		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: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet C  
Part I  
Date/Time Prepared:  
1/26/2015 10:54 am

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00		4.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	12,909,486		12,909,486	7,280	12,916,766	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	246,662		246,662	0	246,662	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	435,075		435,075	0	435,075	54.00
60.00	06000 LABORATORY	881,177		881,177	0	881,177	60.00
65.00	06500 RESPIRATORY THERAPY	1,641,628	0	1,641,628	0	1,641,628	65.00
66.00	06600 PHYSICAL THERAPY	1,752,695	0	1,752,695	0	1,752,695	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	2,007,549		2,007,549	0	2,007,549	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,511,838		2,511,838	0	2,511,838	73.00
74.00	07400 RENAL DIALYSIS	412,373		412,373	0	412,373	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
100.00	10000 I&R SERVICES - NOT APPRVD. PRGM.	0		0	0	0	100.00
200.00	Subtotal (see instructions)	22,798,483	0	22,798,483	7,280	22,805,763	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	22,798,483	0	22,798,483	7,280	22,805,763	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet C  
Part I  
Date/Time Prepared:  
1/26/2015 10:54 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	25,016,428		25,016,428		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	590,070	0	590,070	0.418022	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,661,779	0	1,661,779	0.261813	54.00
60.00	06000	LABORATORY	5,873,089	0	5,873,089	0.150036	60.00
65.00	06500	RESPIRATORY THERAPY	10,699,686	0	10,699,686	0.153428	65.00
66.00	06600	PHYSICAL THERAPY	4,094,157	0	4,094,157	0.428097	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,581,587	0	5,581,587	0.359674	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,268,798	0	17,268,798	0.145455	73.00
74.00	07400	RENAL DIALYSIS	1,057,835	0	1,057,835	0.389827	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0		100.00
200.00		Subtotal (see instructions)	71,843,429	0	71,843,429		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	71,843,429	0	71,843,429		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet C Part I Date/Time Prepared: 1/26/2015 10:54 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		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
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
100.00	10000 I&R SERVICES - NOT APPRVD. PRGM.			100.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 142006		Period: From 09/01/2013 To 08/31/2014		Worksheet D Part I Date/Time Prepared: 1/26/2015 10:54 am	
		Title XVIII		Hospital		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,111,423	0	3,111,423	14,434	215.56	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)	3,111,423		3,111,423	14,434		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	6,384	1,376,135				
31.00	INTENSIVE CARE UNIT	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (Lines 30-199)	6,384	1,376,135				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet D Part II Date/Time Prepared: 1/26/2015 10:54 am
--	--	----------------------	---	---

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	14,971	590,070	0.025372	357,650	9,074	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	81,021	1,661,779	0.048756	655,824	31,975	54.00
60.00	06000 LABORATORY	170,031	5,873,089	0.028951	2,731,073	79,067	60.00
65.00	06500 RESPIRATORY THERAPY	178,504	10,699,686	0.016683	4,490,410	74,914	65.00
66.00	06600 PHYSICAL THERAPY	287,451	4,094,157	0.070210	1,780,238	124,991	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	617,358	5,581,587	0.110606	2,641,916	292,212	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	268,251	17,268,798	0.015534	7,841,423	121,809	73.00
74.00	07400 RENAL DIALYSIS	18,096	1,057,835	0.017107	596,947	10,212	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (Lines 50-199)	1,635,683	46,827,001		21,095,481	744,254	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142006		Period: From 09/01/2013 To 08/31/2014		Worksheet D Part III Date/Time Prepared: 1/26/2015 10:54 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,434	0.00	6,384	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)	14,434		6,384	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	590,070	0.000000	0.000000	357,650	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,661,779	0.000000	0.000000	655,824	54.00
60.00	06000 LABORATORY	0	5,873,089	0.000000	0.000000	2,731,073	60.00
65.00	06500 RESPIRATORY THERAPY	0	10,699,686	0.000000	0.000000	4,490,410	65.00
66.00	06600 PHYSICAL THERAPY	0	4,094,157	0.000000	0.000000	1,780,238	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,581,587	0.000000	0.000000	2,641,916	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	17,268,798	0.000000	0.000000	7,841,423	73.00
74.00	07400 RENAL DIALYSIS	0	1,057,835	0.000000	0.000000	596,947	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0.000000	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00	Total (Lines 50-199)	0	46,827,001			21,095,481	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XVIII Hospital PPS						
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	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
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	0	0	0		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00	Total (Lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet D  
Part V  
Date/Time Prepared:  
1/26/2015 10:54 am

		Title XVIII		Hospital		PPS	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.418022	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.261813	0	21,026	0	0	54.00
60.00	06000 LABORATORY	0.150036	0	1,373	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.153428	0	26,997	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.428097	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359674	0	3,912	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.145455	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.389827	0	14,465	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0.000000		0			95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Subtotal (see instructions)		0	67,773	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	67,773	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet D  
Part V  
Date/Time Prepared:  
1/26/2015 10:54 am

Title XVIII

Hospital

PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,505	0	54.00
60.00	06000 LABORATORY	206	0	60.00
65.00	06500 RESPIRATORY THERAPY	4,142	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	1,407	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	5,639	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00	Subtotal (see instructions)	16,899	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	16,899	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 1/26/2015 10:54 am
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,434	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,434	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)		14,434	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		6,384	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		12,916,766	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)		12,916,766	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		12,916,766	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		894.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,712,914	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)		5,712,914	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142006		Period: From 09/01/2013 To 08/31/2014		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 1/26/2015 10:54 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	0	0	0.00	0	0		43.00
44.00							44.00
45.00							45.00
46.00							46.00
47.00							47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,505,546	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,218,460	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)					1,376,135	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					744,254	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,120,389	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,098,071	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: 142006		Period: From 09/01/2013 To 08/31/2014		Worksheet D-1 Date/Time Prepared: 1/26/2015 10:54 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,111,423	12,916,766	0.240883	0	0	90.00
91.00	Nursing School cost	0	12,916,766	0.000000	0	0	91.00
92.00	Allied health cost	0	12,916,766	0.000000	0	0	92.00
93.00	All other Medical Education	0	12,916,766	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 1/26/2015 10:54 am
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,434	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,434	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)		14,434	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)		4,459	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		12,909,486	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)		12,909,486	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		12,909,486	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		894.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,988,040	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)		3,988,040	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142006		Period: From 09/01/2013 To 08/31/2014		Worksheet D-1	
Date/Time Prepared: 1/26/2015 10:54 am		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	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)					2,919,746		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,907,786		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/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: 142006		Period: From 09/01/2013 To 08/31/2014		Worksheet D-1 Date/Time Prepared: 1/26/2015 10:54 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,111,423	12,909,486	0.241018	0	0	90.00
91.00	Nursing School cost	0	12,909,486	0.000000	0	0	91.00
92.00	Allied health cost	0	12,909,486	0.000000	0	0	92.00
93.00	All other Medical Education	0	12,909,486	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet D-2

Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program Inpatient Days Title V															
	1.00	2.00	3.00	4.00	5.00															
<b>PART I - NOT IN APPROVED TEACHING PROGRAM</b>																				
Hospital Inpatient Routine Services:																				
1.00 Total cost of services rendered	0.00	0				1.00														
2.00 ADULTS & PEDIATRICS	0.00	0	14,434	0.00	0	2.00														
3.00 INTENSIVE CARE UNIT	0.00	0	0	0.00	0	3.00														
4.00 CORONARY CARE UNIT						4.00														
5.00 BURN INTENSIVE CARE UNIT						5.00														
6.00 SURGICAL INTENSIVE CARE UNIT						6.00														
7.00 OTHER SPECIAL CARE (SPECIFY)						7.00														
8.00 NURSERY						8.00														
9.00 Subtotal (sum of lines 2 through 8)	0.00	0				9.00														
10.00 SUBPROVIDER - IPF						10.00														
11.00 SUBPROVIDER - IRF						11.00														
12.00 SUBPROVIDER						12.00														
13.00 SKILLED NURSING FACILITY	0.00	0	0	0.00	0	13.00														
14.00 NURSING FACILITY						14.00														
15.00 OTHER LONG TERM CARE						15.00														
16.00 HOME HEALTH AGENCY						16.00														
17.00 CMHC						17.00														
18.00 AMBULATORY SURGICAL CENTER (D.P.)						18.00														
19.00 HOSPICE						19.00														
20.00 Subtotal (sum of lines 9 through 19)	0.00	0				20.00														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th></th> <th></th> <th>Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)</th> <th>Ratio of Cost to Charges (col. 2 ÷ col. 3)</th> <th>Titles V and XIX Outpatient and Title XVIII Part B Charges Title V</th> <th></th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td> </tr> </thead> </table>							Cost Center Description			Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V			1.00	2.00	3.00	4.00	5.00	
Cost Center Description			Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V															
	1.00	2.00	3.00	4.00	5.00															
Hospital Outpatient Services:																				
21.00 RURAL HEALTH CLINIC						21.00														
22.00 FEDERALLY QUALIFIED HEALTH CENTER						22.00														
23.00 CLINIC	0.00	0	0	0.000000	0	23.00														
24.00 EMERGENCY	0.00	0	0	0.000000	0	24.00														
25.00 OBSERVATION BEDS (NON-DISTINCT PART)						25.00														
26.00 OTHER OUTPATIENT SERVICE COST CENTER						26.00														
27.00 Subtotal (sum of lines 21 through 26)	0.00	0				27.00														
28.00 Total (sum of lines 20 and 27)	0.00	0				28.00														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th>Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22</th> <th>Swing bed Amount</th> <th>Net cost (column 1 plus column 2)</th> <th>Total Inpatient Days - All Patients</th> <th>Average Cost Per Day (col. 3 ÷ col. 4)</th> <th></th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td> </tr> </thead> </table>							Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)			1.00	2.00	3.00	4.00	5.00	
Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)															
	1.00	2.00	3.00	4.00	5.00															
<b>PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)</b>																				
Hospital Inpatient Routine Services:																				
29.00 ADULTS & PEDIATRICS	0	0	0	14,434	0.00	29.00														
30.00 Swing Bed - SNF				0	0.00	30.00														
31.00 Swing Bed - NF				0		31.00														
32.00 INTENSIVE CARE UNIT	0			0	0.00	32.00														
33.00 CORONARY CARE UNIT						33.00														
34.00 BURN INTENSIVE CARE UNIT						34.00														
35.00 SURGICAL INTENSIVE CARE UNIT						35.00														
36.00 OTHER SPECIAL CARE (SPECIFY)						36.00														
37.00 Subtotal (sum of lines 28, and 29 through 36)	0			0		37.00														
38.00 SUBPROVIDER - IPF						38.00														
39.00 SUBPROVIDER - IRF						39.00														
40.00 SUBPROVIDER						40.00														
41.00 SKILLED NURSING FACILITY	0			0	0.00	41.00														
42.00 Total (sum of lines 37 through 41)	0			0		42.00														

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet D-2

Date/Time Prepared:  
1/26/2015 10:54 am

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

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet D-2

Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description	Health Care Program Inpatient Days		Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)		
	Title XVIII, Part B Only Less Part A Coverage but no Part B Coverage	Title XIX					
	6.00	7.00					
<b>PART I - NOT IN APPROVED TEACHING PROGRAM</b>							
1.00	Total cost of services rendered					1.00	
Hospital Inpatient Routine Services:							
2.00	ADULTS & PEDIATRICS	6,384	4,459	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			
<b>PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)</b>							
Hospital Inpatient Routine Services:							
29.00	ADULTS & PEDIATRICS	0	0	0			29.00
30.00	Swing Bed - SNF	0	0				30.00
31.00	Swing Bed - NF						31.00
32.00	INTENSIVE CARE UNIT	0	0	0			32.00
33.00	CORONARY CARE UNIT						33.00
34.00	BURN INTENSIVE CARE UNIT						34.00
35.00	SURGICAL INTENSIVE CARE UNIT						35.00
36.00	OTHER SPECIAL CARE (SPECIFY)						36.00
37.00	Subtotal (sum of lines 28, and 29 through 36)		0	0			37.00
38.00	SUBPROVIDER - IPF						38.00
39.00	SUBPROVIDER - IRF						39.00
40.00	SUBPROVIDER						40.00
41.00	SKILLED NURSING FACILITY	0	0	0			41.00
42.00	Total (sum of lines 37 through 41)		0	0			42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet D-2

Date/Time Prepared:  
1/26/2015 10:54 am

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet D-3 Date/Time Prepared: 1/26/2015 10:54 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		11,074,561		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.418022	357,650	149,506	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.261813	655,824	171,703	54.00
60.00	06000 LABORATORY	0.150036	2,731,073	409,759	60.00
65.00	06500 RESPIRATORY THERAPY	0.153428	4,490,410	688,955	65.00
66.00	06600 PHYSICAL THERAPY	0.428097	1,780,238	762,115	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	0.359674	2,641,916	950,228	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.145455	7,841,423	1,140,574	73.00
74.00	07400 RENAL DIALYSIS	0.389827	596,947	232,706	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)		21,095,481	4,505,546	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)		21,095,481		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet D-3 Date/Time Prepared: 1/26/2015 10:54 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		7,684,283		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.418022	156,025	65,222	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.261813	492,624	128,975	54.00
60.00	06000 LABORATORY	0.150036	1,688,313	253,308	60.00
65.00	06500 RESPIRATORY THERAPY	0.153428	3,153,503	483,836	65.00
66.00	06600 PHYSICAL THERAPY	0.428097	1,233,947	528,249	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	0.359674	1,554,039	558,947	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.145455	5,360,541	779,717	73.00
74.00	07400 RENAL DIALYSIS	0.389827	311,655	121,492	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)		13,950,647	2,919,746	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		13,950,647		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet E Part B Date/Time Prepared: 1/26/2015 10:54 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		16,899	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)		16,899	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		67,773	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)		67,773	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		67,773	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		50,874	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)		16,899	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		13,555	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)		3,344	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)		3,344	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		3,344	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		3,344	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,344	40.00
40.01	Sequestration adjustment (see instructions)		67	40.01
41.00	Interim payments		8,456	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-5,179	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet E-1  
Part I  
Date/Time Prepared:  
1/26/2015 10:54 am

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		12,382,317		8,456	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	12/02/2013	53,600		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	11/30/2014	909,200		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)		-855,600		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)		11,526,717		8,456	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		2,206		5,179	6.02
7.00	Total Medicare program liability (see instructions)		11,524,511		3,277	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: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet E-3 Part IV Date/Time Prepared: 1/26/2015 10:54 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART IV - MEDICARE PART A SERVICES - LTCH PPS</b>				
1.00	Net Federal PPS Payments (see instructions)		11,673,594	1.00
2.00	Outlier Payments		490,712	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		12,164,306	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 physicians' services in a teaching hospital (see instructions)		0	6.00
7.00	Subtotal (see instructions)		12,164,306	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8)		12,164,306	9.00
10.00	Deductibles		28,768	10.00
11.00	Subtotal (line 9 minus line 10)		12,135,538	11.00
12.00	Coinsurance		586,056	12.00
13.00	Subtotal (line 11 minus line 12)		11,549,482	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		323,420	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		210,223	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		264,795	16.00
17.00	Subtotal (sum of lines 13 and 15)		11,759,705	17.00
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.99	Recovery of Accelerated Depreciation		0	21.99
22.00	Total amount payable to the provider (see instructions)		11,759,705	22.00
22.01	Sequestration adjustment (see instructions)		235,194	22.01
23.00	Interim payments		11,526,717	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)		-2,206	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	26.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions)		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 (see instructions)		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142006	Period: From 09/01/2013 To 08/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 1/26/2015 10:54 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		6,907,786		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)		6,907,786	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)		6,907,786	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		7,684,283		8.00
9.00	Ancillary service charges		13,950,647	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)		21,634,930	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		21,634,930	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		14,727,144	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		6,907,786	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		6,907,786	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		6,907,786	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		6,907,786	0	36.00
37.00	OTHER ADJUSTMENTS		0		37.00
37.01	OTHER ADJUSTMENTS		0		37.01
38.00	Subtotal (line 36 ± line 37)		6,907,786	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)		6,907,786	0	40.00
41.00	Interim payments		5,568,674		41.00
42.00	Balance due provider/program (line 40 minus line 41)		1,339,112		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		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: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet G

Date/Time Prepared:  
1/26/2015 10:54 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	198,465	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,795,359	0	0	0	4.00
5.00	Other receivable	-21,762	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-794,212	0	0	0	6.00
7.00	Inventory	213,260	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)	4,391,110	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	7,926,052	0	0	0	17.00
18.00	Accumulated depreciation	-7,437,737	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	3,933,163	0	0	0	23.00
24.00	Accumulated depreciation	-3,187,552	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)	1,233,926	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	5,800	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,800	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	5,630,836	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	560,325	0	0	0	37.00
38.00	Salaries, wages, and fees payable	492,727	0	0	0	38.00
39.00	Payroll taxes payable	1,416	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	434,325	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,488,793	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-48,095,952	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-48,095,952	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-46,607,159	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	52,237,995				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)	52,237,995	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	5,630,836	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet G-1

Date/Time Prepared:  
1/26/2015 10:54 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		50,987,720		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,250,272			2.00
3.00	Total (sum of line 1 and line 2)		52,237,992		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)		52,237,995		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)		52,237,995		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: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
1/26/2015 10:54 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	25,016,428		25,016,428	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)	25,016,428		25,016,428	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	25,016,428		25,016,428	17.00
18.00	Ancillary services	46,827,001	0	46,827,001	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)	71,843,429	0	71,843,429	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,765,488		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)		23,765,488		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 142006

Period:  
From 09/01/2013  
To 08/31/2014

Worksheet G-3

Date/Time Prepared:  
1/26/2015 10:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	71,843,429	1.00
2.00	Less contractual allowances and discounts on patients' accounts	46,902,112	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,941,317	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,765,488	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,175,829	5.00
<b>OTHER INCOME</b>			
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	1,970	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	27,001	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	3,812	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	41,660	24.00
25.00	Total other income (sum of lines 6-24)	74,443	25.00
26.00	Total (line 5 plus line 25)	1,250,272	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)	1,250,272	29.00