

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: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet S Parts I-III Date/Time Prepared: 1/26/2015 11:00 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 1/26/2015	Time: 11:00 am
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 Chicago (142008) 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 V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	14,915	51,319	0	8,904,396	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
200.00 Total	0	14,915	51,319	0	8,904,396	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: 142008		Period: From 09/01/2013 To 08/31/2014		Worksheet S-2 Part I Date/Time Prepared: 1/26/2015 10:59 am			
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 365 East North Avenue		PO Box:				1.00		
2.00	City: Northlake		State: IL		Zip Code: 60164		County: Cook		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
				2.00	3.00	4.00	5.00	6.00	7.00 8.00
		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 Chicago		142008	16974	2	04/01/1991	N P O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2013	08/31/2014	
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	
22.01	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	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.			0	0	0	0	0	0
							Urban/Rural S	Date of Geogr	
							1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00

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		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					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

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
	1.00	2.00	3.00	4.00		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20	
				1.00		
<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	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
<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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have 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
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					Y	80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						106.00

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		V	XIX			
		1.00	2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			
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			
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	257,160	0	1,320,014		
		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			
119.00	DO NOT USE THIS LINE					
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			
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			
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.					
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.					
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.					
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.					
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.					
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.					
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.					
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.					
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.					
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	189003		

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1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: KINDRED HEALTHCARE INC	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		Contractor's Number: 05901			
142.00	Street: 680 SOUTH FOURTH AVENUE	PO Box:					
143.00	City: LOUISVILLE	State: KY	Zip Code: 40202				
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?				Y		
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		
				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		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N		
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
				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		
		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							0.00
166.02							0.00
166.03							0.00
				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		
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		
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		
				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)						

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet S-2 Part II Date/Time Prepared: 1/26/2015 10:59 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.			Y	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	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: 142008

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

Worksheet S-2
Part II
Date/Time Prepared:
1/26/2015 10:59 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	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2014	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
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN		HOURIGAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	KINDRED HEALTHCARE INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5025967856		Daniel.Hourigan@kindred.com	43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142008

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

Worksheet S-3
Part I
Date/Time Prepared:
1/26/2015 10:59 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					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	245	89,425	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)		245	89,425	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)		245	89,425	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)		245				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: 142008

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

Worksheet S-3
Part I
Date/Time Prepared:
1/26/2015 10:59 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)	15,703	30,807	59,995			1.00
2.00 HMO and other (see instructions)	1,430	6,715				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)	15,703	30,807	59,995			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)	15,703	30,807	59,995	0.00	541.40	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	541.40	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	1,183					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142008

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

Worksheet S-3
Part I
Date/Time Prepared:
1/26/2015 10:59 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	612	1,199	2,330	1.00
2.00 HMO and other (see instructions)				44	358		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		612	1,199	2,330	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: 142008		Period: From 09/01/2013 To 08/31/2014		Worksheet S-3 Part II Date/Time Prepared: 1/26/2015 10:59 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		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	31,668,544	0	31,668,544	1,126,241.00	28.12	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	1,759	1,759	41.00	42.90	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		5,318,994	0	5,318,994	96,396.00	55.18	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		1,189,289	0	1,189,289	12,812.00	92.83	13.00
14.00	Home office salaries & wage-related costs		3,020,742	0	3,020,742	67,127.00	45.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		4,865,390	0	4,865,390			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		270	0	270			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	115,021	0	115,021	2,747.00	41.87	26.00
27.00	Administrative & General	5.00	3,940,840	0	3,940,840	99,188.00	39.73	27.00
28.00	Administrative & General under contract (see inst.)		8,075	0	8,075	615.00	13.13	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	298,678	0	298,678	20,692.00	14.43	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	755,507	0	755,507	62,190.00	12.15	32.00
33.00	Housekeeping under contract (see instructions)		27,464	0	27,464	1,734.00	15.84	33.00
34.00	Dietary	10.00	864,950	0	864,950	54,268.00	15.94	34.00
35.00	Dietary under contract (see instructions)		43,679	0	43,679	2,575.00	16.96	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,599,465	0	1,599,465	36,716.00	43.56	38.00
39.00	Central Services and Supply	14.00	227,999	0	227,999	16,210.00	14.07	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 142008		Period: From 09/01/2013 To 08/31/2014		Worksheet S-3 Part II Date/Time Prepared: 1/26/2015 10:59 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		
41.00	Medical Records & Medical Records Library	16.00	1,146,345	0	1,146,345	38,618.00	29.68	41.00
42.00	Social Service	17.00	1,190,294	-1,759	1,188,535	27,554.00	43.13	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142008

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

Worksheet S-3
Part III
Date/Time Prepared:
1/26/2015 10:59 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	31,747,762	0	31,747,762	1,131,165.00	28.07	1.00
2.00	Excluded area salaries (see instructions)	0	1,759	1,759	41.00	42.90	2.00
3.00	Subtotal salaries (line 1 minus line 2)	31,747,762	-1,759	31,746,003	1,131,124.00	28.07	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,529,025	0	9,529,025	176,335.00	54.04	4.00
5.00	Subtotal wage-related costs (see inst.)	4,865,390	0	4,865,390	0.00	15.33	5.00
6.00	Total (sum of lines 3 thru 5)	46,142,177	-1,759	46,140,418	1,307,459.00	35.29	6.00
7.00	Total overhead cost (see instructions)	10,218,317	-1,759	10,216,558	363,107.00	28.14	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet S-3 Part IV Date/Time Prepared: 1/26/2015 10:59 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	2,139	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	1,305,240	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-17,976	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	24,376	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)	123,589	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	680,895	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,309,649	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	374,324	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	63,153	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,865,389	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 142008

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

Worksheet S-7

Date/Time Prepared:
1/26/2015 10:59 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
				1.00	2.00
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	0	0	0	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	0	0	0	15.00
16.00	RVB	0	0	0	16.00
17.00	RVA	0	0	0	17.00
18.00	RHC	0	0	0	18.00
19.00	RHB	0	0	0	19.00
20.00	RHA	0	0	0	20.00
21.00	RMC	0	0	0	21.00
22.00	RMB	0	0	0	22.00
23.00	RMA	0	0	0	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	0	0	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	0	0	0	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	0	0	0	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	0	0	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	0	0	0	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	0	0	0	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	0	0	0	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	0	0	0	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 142008

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

Worksheet S-7

Date/Time Prepared:
1/26/2015 10:59 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)
		1.00	2.00

201.00 SNF SERVICES
 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). 201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?
		1.00	2.00	3.00

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	0	0.00	202.00
203.00	Recruitment	0	0.00	203.00
204.00	Retention of employees	0	0.00	204.00
205.00	Training	0	0.00	205.00
206.00	OTHER (SPECIFY)	0	0.00	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	0		207.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142008

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

Worksheet A
Date/Time Prepared:
1/26/2015 10:59 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	
GENERAL SERVICE COST CENTERS							
1.00	00100		9,878,424	9,878,424	1,086,338	10,964,762	1.00
2.00	00200		1,786,112	1,786,112	471,957	2,258,069	2.00
3.00	00300		1,558,295	1,558,295	-1,558,295	0	3.00
4.00	00400	115,021	5,133,921	5,248,942	0	5,248,942	4.00
5.00	00500	3,940,840	23,707,941	27,648,781	0	27,648,781	5.00
7.00	00700	298,678	3,180,323	3,479,001	0	3,479,001	7.00
8.00	00800	0	503,670	503,670	0	503,670	8.00
9.00	00900	755,507	224,210	979,717	0	979,717	9.00
10.00	01000	864,950	972,018	1,836,968	0	1,836,968	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	1,599,465	18,841	1,618,306	0	1,618,306	13.00
14.00	01400	227,999	187,536	415,535	0	415,535	14.00
15.00	01500	0	1,945,294	1,945,294	0	1,945,294	15.00
16.00	01600	1,146,345	288,279	1,434,624	0	1,434,624	16.00
17.00	01700	1,190,294	95,242	1,285,536	-1,900	1,283,636	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	13,763,313	2,707,143	16,470,456	2,905,892	19,376,348	30.00
31.00	03100	2,793,811	112,081	2,905,892	-2,905,892	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	320,982	358,963	679,945	0	679,945	50.00
54.00	05400	234,459	151,222	385,681	0	385,681	54.00
60.00	06000	688,331	762,679	1,451,010	0	1,451,010	60.00
65.00	06500	3,669,110	60,044	3,729,154	0	3,729,154	65.00
66.00	06600	0	2,827,270	2,827,270	0	2,827,270	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	3,589,256	3,589,256	0	3,589,256	71.00
73.00	07300	0	3,500,648	3,500,648	0	3,500,648	73.00
74.00	07400	59,439	1,253,902	1,313,341	0	1,313,341	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09500	0	0	0	0	0	98.00
100.00	10000	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		31,668,544	64,803,314	96,471,858	-1,900	96,469,958	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	1,900	1,900	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		31,668,544	64,803,314	96,471,858	0	96,471,858	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142008

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

Worksheet A
Date/Time Prepared:
1/26/2015 10:59 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,498,701	9,466,061	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-112,024	2,146,045	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,902	5,242,040	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,565,790	21,082,991	5.00
7.00	00700	OPERATION OF PLANT	134,276	3,613,277	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	503,670	8.00
9.00	00900	HOUSEKEEPING	36,070	1,015,787	9.00
10.00	01000	DIETARY	-124,876	1,712,092	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,443	1,619,749	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	415,535	14.00
15.00	01500	PHARMACY	0	1,945,294	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,506	1,428,118	16.00
17.00	01700	SOCIAL SERVICE	0	1,283,636	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,070,274	18,306,074	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	-234,446	445,499	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	385,681	54.00
60.00	06000	LABORATORY	-23,162	1,427,848	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,729,154	65.00
66.00	06600	PHYSICAL THERAPY	-153,856	2,673,414	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	3,589,256	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,500,648	73.00
74.00	07400	RENAL DIALYSIS	0	1,313,341	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	100.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-9,624,748	86,845,210	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	1,900	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)	-9,624,748	86,847,110	200.00

RECLASSIFICATIONS

Provider CCN: 142008

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

Worksheet A-6

Date/Time Prepared:
1/26/2015 10:59 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	1,759	141	1.00
	TOTALS			1,759	141	
C - RCL ICU EXPENSE						
1.00	ADULTS & PEDIATRICS		30.00	2,793,811	112,081	1.00
	TOTALS			2,793,811	112,081	
500.00	Grand Total: Increases			2,795,570	112,222	500.00

RECLASSIFICATIONS

Provider CCN: 142008

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

Worksheet A-6

Date/Time Prepared:
1/26/2015 10:59 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	1,759	141		0	1.00
	TOTALS			1,759	141			
C - RCL ICU EXPENSE								
1.00	INTENSIVE CARE UNIT		31.00	2,793,811	112,081		0	1.00
	TOTALS			2,793,811	112,081			
500.00	Grand Total: Decreases			2,795,570	112,222			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142008

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

Worksheet A-7
Part I
Date/Time Prepared:
1/26/2015 10:59 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	675,156	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	30,992,575	2,580,313	0	2,580,313	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	14,488,356	460,498	0	460,498	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	46,156,087	3,040,811	0	3,040,811	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	46,156,087	3,040,811	0	3,040,811	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	675,156	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	33,572,888	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	14,879,017	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	49,127,061	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	49,127,061	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142008

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

Worksheet A-7
Part II
Date/Time Prepared:
1/26/2015 10:59 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	2,571,152	7,307,272	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	832,300	953,812	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,403,452	8,261,084	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	9,878,424				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,786,112				2.00
3.00	Total (sum of lines 1-2)	0	11,664,536				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142008

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

Worksheet A-7
Part III
Date/Time Prepared:
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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	34,248,045	0	34,248,045	0.697132	86,872	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,879,017	0	14,879,017	0.302868	37,741	2.00
3.00	Total (sum of lines 1-2)	49,127,062	0	49,127,062	1.000000	124,613	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	999,466	0	1,086,338	1,116,066	7,307,272	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	434,216	0	471,957	720,276	953,812	2.00
3.00	Total (sum of lines 1-2)	1,433,682	0	1,558,295	1,836,342	8,261,084	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	43,257	999,466	0	9,466,061	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	37,741	434,216	0	2,146,045	2.00
3.00	Total (sum of lines 1-2)	0	80,998	1,433,682	0	11,612,106	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 142008

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

Worksheet A-8

Date/Time Prepared:
1/26/2015 10:59 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	-5,241		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	-56,528		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-4,176		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	-1,326,440				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	130,781				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-124,876		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	-6,506		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	-258,053		ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 142008

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

Worksheet A-8

Date/Time Prepared:
1/26/2015 10:59 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	-578	ADMINISTRATIVE & GENERAL		5.00	0 33.05
33.06	PATIENT PERSONAL SERVICES EXPENSE	-8	ADMINISTRATIVE & GENERAL		5.00	0 33.06
33.07	PROFESSIONAL FEES - CAPITAL PROJECT	-63,677	ADMINISTRATIVE & GENERAL		5.00	0 33.07
33.08	MEDICARE BAD DEBT - PART A	-1,627,107	ADMINISTRATIVE & GENERAL		5.00	0 33.08
33.09		0			0.00	0 33.09
33.10	OTHER MEDICARE NON ALLOWABLE	-108,641	ADMINISTRATIVE & GENERAL		5.00	0 33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	-338	ADMINISTRATIVE & GENERAL		5.00	0 33.11
33.12	OTHER OPERATING - PUBLIC RELATIONS	-9	ADMINISTRATIVE & GENERAL		5.00	0 33.12
33.13	OTHER OPERATING - MARKETING	-37,857	ADMINISTRATIVE & GENERAL		5.00	0 33.13
33.14		0			0.00	0 33.14
33.15	OTHER OPERATING - CASH OVER SHORT	-58	ADMINISTRATIVE & GENERAL		5.00	0 33.15
33.16		0			0.00	0 33.16
33.17	OTHER OPER - LITIGATION SETTLEMENT	-292,550	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	-4,822	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	-42,194	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	-80,194	ADMINISTRATIVE & GENERAL		5.00	0 33.28
33.29	CABLE TV AND SATELLITE	-47,695	ADMINISTRATIVE & GENERAL		5.00	0 33.29
33.30		0			0.00	0 33.30
33.31	MARKETING BONUS	-1,478	ADMINISTRATIVE & GENERAL		5.00	0 33.31
33.32	RENT - OTHER	-4,499,135	ADMINISTRATIVE & GENERAL		5.00	0 33.32
33.33		0			0.00	0 33.33
33.34	MALPRACTICE TAIL LIABILITY	248,339	ADMINISTRATIVE & GENERAL		5.00	0 33.34
33.35	AGGREGATE CAP PYMT-NONALLOWABLE	122,135	ADMINISTRATIVE & GENERAL		5.00	0 33.35
33.36		0			0.00	0 33.36
33.37	PHYSICIAN BILLING COLLECTION FEES	-7,650	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	-1,612,241	CAP REL COSTS-BLDG & FIXT		1.00	9 34.00
34.01	MEDICARE VS BOOK MOV EQUIP	-380,336	CAP REL COSTS-MVBLE EQUIP		2.00	9 34.01
34.02	ASSET ADD-ON BLDG	41,650	CAP REL COSTS-BLDG & FIXT		1.00	9 34.02
34.03	ASSET ADD-ON MOV EQUIP	257,626	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	-18,730	ADMINISTRATIVE & GENERAL		5.00	0 34.06
34.07		0			0.00	0 34.07
34.08	BUSINESS INTERRUPTION INS PREMIUM	-43,615	CAP REL COSTS-BLDG & FIXT		1.00	12 34.08
34.09	REGIONAL OFFICE ALLOC - BLDG DEPREC	115,505	CAP REL COSTS-BLDG & FIXT		1.00	9 34.09
34.10	REGIONAL OFFICE ALLOC - EQUIP DEPREC	18,077	CAP REL COSTS-MVBLE EQUIP		2.00	9 34.10
34.11	REGIONAL OFFICE ALLOC - PLANT OPER	138,452	OPERATION OF PLANT		7.00	0 34.11
34.12	REGIONAL OFFICE ALLOC - HOUSEKEEPING	36,070	HOUSEKEEPING		9.00	0 34.12
34.13		0			0.00	0 34.13
34.14	PATIENT PHONE - DEPREC EQUIP	-7,391	CAP REL COSTS-MVBLE EQUIP		2.00	9 34.14
34.15		0			0.00	0 34.15
34.16		0			0.00	0 34.16

Provider CCN: 142008

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

Worksheet A-8

Date/Time Prepared:
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00		3.00	4.00
34.17		0			0.00	0	34.17
34.18		0			0.00	0	34.18
34.19		0			0.00	0	34.19
34.20		0			0.00	0	34.20
34.21		0			0.00	0	34.21
34.22	A	-68,358	ADMINISTRATIVE & GENERAL		5.00	0	34.22
34.23	A	-6,902	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		0			0.00	0	35.01
35.02		0			0.00	0	35.02
35.03		0			0.00	0	35.03
35.04		0			0.00	0	35.04
35.05		0			0.00	0	35.05
35.06	A	1,443	NURSING ADMINISTRATION		13.00	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	A	-6,001	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	A	4,559	OPERATING ROOM		50.00	0	35.14
35.15		0			0.00	0	35.15
35.16		0			0.00	0	35.16
35.17		0			0.00	0	35.17
35.18		0			0.00	0	35.18
35.19		0			0.00	0	35.19
35.20		0			0.00	0	35.20
35.21		0			0.00	0	35.21
35.22		0			0.00	0	35.22
35.23		0			0.00	0	35.23
35.24		0			0.00	0	35.24
35.25		0			0.00	0	35.25
50.00		-9,624,748					50.00
TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)							

(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: 142008
 Period: From 09/01/2013 To 08/31/2014
 Worksheet A-8-1
 Date/Time Prepared: 1/26/2015 10:59 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	4,776,750	1.00
2.00	4.00	EMPLOYEE BENEFITS	Workers Comp Premium	711,211	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	1,443,228	3.00
4.00	0.00			0	4.00
4.01	66.00	PHYSICAL THERAPY	Therapy Services	2,824,960	4.01
4.02	0.00			0	4.02
4.03	0.00			0	4.03
4.04	0.00			0	4.04
4.05	0.00			0	4.05
5.00	0			9,756,149	5.00

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

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

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

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

6.00	B	Kindred Inc-Hos	100.00	Admin & Gen	100.00	6.00
7.00	B	Kindred Inc-Hos	100.00	Cornerstone	100.00	7.00
8.00	B	Kindred Inc-Hos	100.00	Cornerstone	100.00	8.00
9.00			0.00		0.00	9.00
10.00	B	Kindred Inc-Hos	100.00	RehabCare	100.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 142008

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

Worksheet A-8-1

Date/Time Prepared:
1/26/2015 10:59 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	284,637	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	-153,856	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	130,781			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 142008

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

Worksheet A-8-2

Date/Time Prepared:
1/26/2015 10:59 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	30.00	DR. A	340,061	0	340,061	177,200	4,534	1.00
2.00	30.00	DR. B	524,096	524,096	0	177,200	0	2.00
3.00	30.00	DR. C	4,565	4,565	0	177,200	0	3.00
4.00	30.00	DR. D	10,168	0	10,168	177,200	62	4.00
5.00	50.00	DR. E	4,560	0	4,560	208,000	24	5.00
6.00	30.00	DR. F	20,995	0	20,995	177,200	124	6.00
7.00	30.00	DR. G	9,750	9,750	0	177,200	0	7.00
8.00	30.00	DR. H	559,379	0	559,379	177,200	6,581	8.00
9.00	30.00	DR. I	278,741	278,741	0	177,200	0	9.00
10.00	30.00	DR. J	32,523	32,523	0	177,200	0	10.00
12.00	30.00	DR. L	10,905	0	10,905	177,200	78	12.00
13.00	30.00	DR. M	17,346	0	17,346	177,200	105	13.00
14.00	30.00	DR. N	14,949	0	14,949	177,200	85	14.00
15.00	60.00	DR. O	53,028	0	53,028	215,700	288	15.00
16.00	30.00	DR. P	7,865	7,865	0	177,200	0	16.00
17.00	30.00	DR. Q	4,500	0	4,500	177,200	30	17.00
18.00	30.00	DR. R	13,410	13,410	0	177,200	0	18.00
19.00	50.00	DR. S	47,475	0	47,475	208,000	211	19.00
20.00	30.00	DR. T	53,988	53,988	0	177,200	0	20.00
21.00	30.00	DR. U	32,208	0	32,208	177,200	265	21.00
22.00	30.00	DR. V	17,977	0	17,977	177,200	106	22.00
23.00	50.00	DR. W	210,470	210,470	0	200,300	0	23.00
24.00	30.00	DR. X	78,060	78,060	0	177,200	0	24.00
25.00	30.00	DR. Y	5,066	5,066	0	177,200	0	25.00
200.00			2,352,085	1,218,534	1,133,551		12,493	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	DR. A	386,262	19,313	0	0	0	1.00
2.00	30.00	DR. B	0	0	0	0	0	2.00
3.00	30.00	DR. C	0	0	0	0	0	3.00
4.00	30.00	DR. D	5,282	264	0	0	0	4.00
5.00	50.00	DR. E	2,400	120	0	0	0	5.00
6.00	30.00	DR. F	10,564	528	0	0	0	6.00
7.00	30.00	DR. G	0	0	0	0	0	7.00
8.00	30.00	DR. H	560,651	28,033	0	0	0	8.00
9.00	30.00	DR. I	0	0	0	0	0	9.00
10.00	30.00	DR. J	0	0	0	0	0	10.00
12.00	30.00	DR. L	6,645	332	0	0	0	12.00
13.00	30.00	DR. M	8,945	447	0	0	0	13.00
14.00	30.00	DR. N	7,241	362	0	0	0	14.00
15.00	60.00	DR. O	29,866	1,493	0	0	0	15.00
16.00	30.00	DR. P	0	0	0	0	0	16.00
17.00	30.00	DR. Q	2,556	128	0	0	0	17.00
18.00	30.00	DR. R	0	0	0	0	0	18.00
19.00	50.00	DR. S	21,100	1,055	0	0	0	19.00
20.00	30.00	DR. T	0	0	0	0	0	20.00
21.00	30.00	DR. U	22,576	1,129	0	0	0	21.00
22.00	30.00	DR. V	9,030	452	0	0	0	22.00
23.00	50.00	DR. W	0	0	0	0	0	23.00
24.00	30.00	DR. X	0	0	0	0	0	24.00
25.00	30.00	DR. Y	0	0	0	0	0	25.00
200.00			1,073,118	53,656	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	DR. A	0	386,262	0	0	1.00
2.00	30.00	DR. B	0	0	0	524,096	2.00
3.00	30.00	DR. C	0	0	0	4,565	3.00
4.00	30.00	DR. D	0	5,282	4,886	4,886	4.00
5.00	50.00	DR. E	0	2,400	2,160	2,160	5.00
6.00	30.00	DR. F	0	10,564	10,431	10,431	6.00
7.00	30.00	DR. G	0	0	0	9,750	7.00
8.00	30.00	DR. H	0	560,651	0	0	8.00
9.00	30.00	DR. I	0	0	0	278,741	9.00
10.00	30.00	DR. J	0	0	0	32,523	10.00
12.00	30.00	DR. L	0	6,645	4,260	4,260	12.00
13.00	30.00	DR. M	0	8,945	8,401	8,401	13.00
14.00	30.00	DR. N	0	7,241	7,708	7,708	14.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 142008

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

Worksheet A-8-2

Date/Time Prepared:
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	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		
15.00	60.00	DR. O	0	29,866	23,162	23,162		15.00
16.00	30.00	DR. P	0	0	0	7,865		16.00
17.00	30.00	DR. Q	0	2,556	1,944	1,944		17.00
18.00	30.00	DR. R	0	0	0	13,410		18.00
19.00	50.00	DR. S	0	21,100	26,375	26,375		19.00
20.00	30.00	DR. T	0	0	0	53,988		20.00
21.00	30.00	DR. U	0	22,576	9,632	9,632		21.00
22.00	30.00	DR. V	0	9,030	8,947	8,947		22.00
23.00	50.00	DR. W	0	0	0	210,470		23.00
24.00	30.00	DR. X	0	0	0	78,060		24.00
25.00	30.00	DR. Y	0	0	0	5,066		25.00
200.00			0	1,073,118	107,906	1,326,440		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142008

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

Worksheet B
Part I
Date/Time Prepared:
1/26/2015 10:59 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	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	9,466,061	9,466,061			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,146,045		2,146,045		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,242,040	272,229	63,915	5,578,184	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	21,082,991	905,900	212,691	696,681	5.00
7.00 00700	OPERATION OF PLANT	3,613,277	1,730,101	406,200	52,802	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	503,670	145,149	34,079	0	8.00
9.00 00900	HOUSEKEEPING	1,015,787	123,383	28,968	133,562	9.00
10.00 01000	DIETARY	1,712,092	500,747	117,567	152,910	10.00
11.00 01100	CAFETERIA	0	101,736	23,886	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,619,749	69,951	16,423	282,761	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	415,535	456,916	107,276	40,307	14.00
15.00 01500	PHARMACY	1,945,294	177,113	41,583	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,428,118	110,681	25,986	202,657	16.00
17.00 01700	SOCIAL SERVICE	1,283,636	28,863	6,777	210,115	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	18,306,074	2,894,335	679,543	2,927,045	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	445,499	348,918	81,920	56,745	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	385,681	127,915	30,032	41,449	54.00
60.00 06000	LABORATORY	1,427,848	135,488	31,810	121,687	60.00
65.00 06500	RESPIRATORY THERAPY	3,729,154	141,392	33,197	648,644	65.00
66.00 06600	PHYSICAL THERAPY	2,673,414	256,605	60,247	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	3,589,256	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	3,500,648	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	1,313,341	60,767	14,267	10,508	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
100.00 10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	86,845,210	8,588,189	2,016,367	5,577,873	85,837,349
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	36,079	8,471	0	44,550
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	NONALLOWABLE CASE MANAGER	1,900	0	0	311	2,211
194.01 07951	IDLE SPACE	0	325,542	0	0	325,542
194.02 07952	REGIONAL OFFICE	0	118,612	27,848	0	146,460
194.03 07953	DISTRICT OFFICE	0	397,639	93,359	0	490,998
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)	86,847,110	9,466,061	2,146,045	5,578,184	86,847,110

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142008

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

Worksheet B
Part I
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,898,263				5.00
7.00	00700	OPERATION OF PLANT	2,109,432	7,911,812			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	248,265	184,265	1,115,428		8.00
9.00	00900	HOUSEKEEPING	473,228	156,633	0	1,931,561	9.00
10.00	01000	DIETARY	902,800	635,692	0	162,183	4,183,991
11.00	01100	CAFETERIA	45,669	129,152	0	32,950	1,634,632
13.00	01300	NURSING ADMINISTRATION	723,051	88,801	0	22,656	0
14.00	01400	CENTRAL SERVICES & SUPPLY	370,829	580,049	0	147,987	0
15.00	01500	PHARMACY	786,710	224,843	0	57,364	0
16.00	01600	MEDICAL RECORDS & LIBRARY	642,546	140,508	0	35,848	0
17.00	01700	SOCIAL SERVICE	556,004	36,641	0	9,348	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,018,495	3,674,322	1,115,428	937,429	2,491,846
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	339,218	442,948	0	113,009	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	212,702	162,386	0	41,429	0
60.00	06000	LABORATORY	624,148	172,001	0	43,882	0
65.00	06500	RESPIRATORY THERAPY	1,655,002	179,496	0	45,795	0
66.00	06600	PHYSICAL THERAPY	1,087,099	325,757	0	83,110	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	1,304,860	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,272,647	0	0	0	0
74.00	07400	RENAL DIALYSIS	508,558	77,143	0	19,681	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,881,263	7,210,637	1,115,428	1,752,671	4,126,478
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,196	45,801	0	11,685	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	804	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	150,576	0	38,416	0
194.03	07953	DISTRICT OFFICE	0	504,798	0	128,789	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	57,513
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	22,898,263	7,911,812	1,115,428	1,931,561	4,183,991

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 142008		Period: From 09/01/2013 To 08/31/2014		Worksheet B Part I Date/Time Prepared: 1/26/2015 10:59 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,968,025					11.00
13.00	01300	82,961	2,906,353				13.00
14.00	01400	36,872	0	2,155,771			14.00
15.00	01500	0	0	9,933	3,242,840		15.00
16.00	01600	87,570	0	1,700	0	2,675,614	16.00
17.00	01700	59,916	0	22	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,322,771	2,866,403	17,960	72,650	1,149,613	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	18,436	39,950	499	610	24,104	50.00
54.00	05400	13,827	0	1,351	6,542	57,611	54.00
60.00	06000	69,134	0	3,820	0	183,574	60.00
65.00	06500	271,929	0	889	0	415,349	65.00
66.00	06600	0	0	492	12	88,532	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	2,119,091	0	179,292	71.00
73.00	07300	0	0	0	3,163,026	535,442	73.00
74.00	07400	4,609	0	14	0	42,097	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	05950	0	0	0	0	0	98.00
100.00	10000	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		1,968,025	2,906,353	2,155,771	3,242,840	2,675,614	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,968,025	2,906,353	2,155,771	3,242,840	2,675,614	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142008

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE	2,191,322			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,191,322	49,665,236	0	49,665,236	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,911,856	0	1,911,856	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,080,925	0	1,080,925	54.00
60.00	06000	LABORATORY	0	2,813,392	0	2,813,392	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,120,847	0	7,120,847	65.00
66.00	06600	PHYSICAL THERAPY	0	4,575,268	0	4,575,268	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	7,192,499	0	7,192,499	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,471,763	0	8,471,763	73.00
74.00	07400	RENAL DIALYSIS	0	2,050,985	0	2,050,985	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	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
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,191,322	84,882,771	0	84,882,771	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	118,232	0	118,232	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	3,015	0	3,015	194.00
194.01	07951	IDLE SPACE	0	325,542	0	325,542	194.01
194.02	07952	REGIONAL OFFICE	0	335,452	0	335,452	194.02
194.03	07953	DISTRICT OFFICE	0	1,124,585	0	1,124,585	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	57,513	0	57,513	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,191,322	86,847,110	0	86,847,110	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet B Part II Date/Time Prepared: 1/26/2015 10:59 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	272,229	63,915	336,144	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	605,292	905,900	212,691	1,723,883	5.00
7.00 00700	OPERATION OF PLANT	0	1,730,101	406,200	2,136,301	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	145,149	34,079	179,228	8.00
9.00 00900	HOUSEKEEPING	0	123,383	28,968	152,351	9.00
10.00 01000	DIETARY	0	500,747	117,567	618,314	10.00
11.00 01100	CAFETERIA	0	101,736	23,886	125,622	11.00
13.00 01300	NURSING ADMINISTRATION	0	69,951	16,423	86,374	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	456,916	107,276	564,192	14.00
15.00 01500	PHARMACY	0	177,113	41,583	218,696	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	110,681	25,986	136,667	16.00
17.00 01700	SOCIAL SERVICE	0	28,863	6,777	35,640	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	2,894,335	679,543	3,573,878	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	348,918	81,920	430,838	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	127,915	30,032	157,947	54.00
60.00 06000	LABORATORY	0	135,488	31,810	167,298	60.00
65.00 06500	RESPIRATORY THERAPY	0	141,392	33,197	174,589	65.00
66.00 06600	PHYSICAL THERAPY	0	256,605	60,247	316,852	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	60,767	14,267	75,034	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09500	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
100.00 10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	605,292	8,588,189	2,016,367	11,209,848	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	36,079	8,471	44,550	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	325,542	0	325,542	194.01
194.02 07952	REGIONAL OFFICE	0	118,612	27,848	146,460	194.02
194.03 07953	DISTRICT OFFICE	0	397,639	93,359	490,998	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07 07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	605,292	9,466,061	2,146,045	12,217,398	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142008		Period: From 09/01/2013 To 08/31/2014		Worksheet B Part II Date/Time Prepared: 1/26/2015 10:59 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,765,865				5.00
7.00	00700	OPERATION OF PLANT	162,676	2,302,159			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,146	53,617	251,991		8.00
9.00	00900	HOUSEKEEPING	36,494	45,577	0	242,470	9.00
10.00	01000	DIETARY	69,622	184,972	0	20,359	902,481
11.00	01100	CAFETERIA	3,522	37,580	0	4,136	352,588
13.00	01300	NURSING ADMINISTRATION	55,760	25,839	0	2,844	0
14.00	01400	CENTRAL SERVICES & SUPPLY	28,598	168,781	0	18,577	0
15.00	01500	PHARMACY	60,670	65,424	0	7,201	0
16.00	01600	MEDICAL RECORDS & LIBRARY	49,552	40,885	0	4,500	0
17.00	01700	SOCIAL SERVICE	42,878	10,662	0	1,173	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	695,483	1,069,145	251,991	117,675	537,487
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	26,160	128,888	0	14,186	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,403	47,251	0	5,201	0
60.00	06000	LABORATORY	48,133	50,048	0	5,509	0
65.00	06500	RESPIRATORY THERAPY	127,631	52,229	0	5,749	0
66.00	06600	PHYSICAL THERAPY	83,835	94,788	0	10,433	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	100,628	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	98,144	0	0	0	0
74.00	07400	RENAL DIALYSIS	39,219	22,447	0	2,471	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,764,554	2,098,133	251,991	220,014	890,075
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,249	13,327	0	1,467	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	62	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	43,814	0	4,822	0
194.03	07953	DISTRICT OFFICE	0	146,885	0	16,167	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	12,406
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)	1,765,865	2,302,159	251,991	242,470	902,481

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142008		Period: From 09/01/2013 To 08/31/2014		Worksheet B Part II Date/Time Prepared: 1/26/2015 10:59 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	523,448					11.00
13.00	01300	22,066	209,922				13.00
14.00	01400	9,807	0	792,384			14.00
15.00	01500	0	0	3,651	355,642		15.00
16.00	01600	23,292	0	625	0	267,733	16.00
17.00	01700	15,936	0	8	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	351,825	207,036	6,602	7,968	115,097	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,903	2,886	184	67	2,411	50.00
54.00	05400	3,678	0	497	717	5,762	54.00
60.00	06000	18,388	0	1,404	0	18,362	60.00
65.00	06500	72,327	0	327	0	41,545	65.00
66.00	06600	0	0	181	1	8,855	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	778,900	0	17,933	71.00
73.00	07300	0	0	0	346,889	53,557	73.00
74.00	07400	1,226	0	5	0	4,211	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	05950	0	0	0	0	0	98.00
100.00	10000	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		523,448	209,922	792,384	355,642	267,733	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		523,448	209,922	792,384	355,642	267,733	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet B Part II Date/Time Prepared: 1/26/2015 10:59 am
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE	118,958			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	118,958	7,229,533	0	7,229,533	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	613,942	0	613,942	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	239,954	0	239,954	54.00
60.00	06000	LABORATORY	0	316,475	0	316,475	60.00
65.00	06500	RESPIRATORY THERAPY	0	513,484	0	513,484	65.00
66.00	06600	PHYSICAL THERAPY	0	514,945	0	514,945	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	897,461	0	897,461	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	498,590	0	498,590	73.00
74.00	07400	RENAL DIALYSIS	0	145,246	0	145,246	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	118,958	10,969,630	0	10,969,630	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	60,593	0	60,593	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	81	0	81	194.00
194.01	07951	IDLE SPACE	0	325,542	0	325,542	194.01
194.02	07952	REGIONAL OFFICE	0	195,096	0	195,096	194.02
194.03	07953	DISTRICT OFFICE	0	654,050	0	654,050	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	12,406	0	12,406	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	118,958	12,217,398	0	12,217,398	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142008

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

Worksheet B-1

Date/Time Prepared:
1/26/2015 10:59 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				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	158,736				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		153,277			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,565	4,565	31,553,523		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	15,191	15,191	3,940,840	-22,898,263	5.00
7.00 00700	OPERATION OF PLANT	29,012	29,012	298,678	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,434	2,434	0	0	8.00
9.00 00900	HOUSEKEEPING	2,069	2,069	755,507	0	9.00
10.00 01000	DIETARY	8,397	8,397	864,950	0	10.00
11.00 01100	CAFETERIA	1,706	1,706	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,173	1,173	1,599,465	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	7,662	7,662	227,999	0	14.00
15.00 01500	PHARMACY	2,970	2,970	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,856	1,856	1,146,345	0	16.00
17.00 01700	SOCIAL SERVICE	484	484	1,188,535	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	48,535	48,535	16,557,124	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,851	5,851	320,982	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,145	2,145	234,459	0	54.00
60.00 06000	LABORATORY	2,272	2,272	688,331	0	60.00
65.00 06500	RESPIRATORY THERAPY	2,371	2,371	3,669,110	0	65.00
66.00 06600	PHYSICAL THERAPY	4,303	4,303	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	1,019	1,019	59,439	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
100.00 10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	144,015	144,015	31,551,764	-22,898,263	62,939,086
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	605	605	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CASE MANAGER	0	0	1,759	0	194.00
194.01 07951	IDLE SPACE	5,459	0	0	-325,542	194.01
194.02 07952	REGIONAL OFFICE	1,989	1,989	0	-146,460	194.02
194.03 07953	DISTRICT OFFICE	6,668	6,668	0	-490,998	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)	9,466,061	2,146,045	5,578,184		22,898,263
203.00	Unit cost multiplier (Wkst. B, Part I)	59.633990	14.001090	0.176785		0.363546
204.00	Cost to be allocated (per Wkst. B, Part II)			336,144		1,765,865
205.00	Unit cost multiplier (Wkst. B, Part II)			0.010653		0.028036

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142008

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	104,509				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,434	59,995			8.00
9.00	00900	HOUSEKEEPING	2,069	0	100,006		9.00
10.00	01000	DIETARY	8,397	0	8,397	216,498	10.00
11.00	01100	CAFETERIA	1,706	0	1,706	84,583	427
13.00	01300	NURSING ADMINISTRATION	1,173	0	1,173	0	18
14.00	01400	CENTRAL SERVICES & SUPPLY	7,662	0	7,662	0	8
15.00	01500	PHARMACY	2,970	0	2,970	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,856	0	1,856	0	19
17.00	01700	SOCIAL SERVICE	484	0	484	0	13
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	48,535	59,995	48,535	128,939	287
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,851	0	5,851	0	4
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,145	0	2,145	0	3
60.00	06000	LABORATORY	2,272	0	2,272	0	15
65.00	06500	RESPIRATORY THERAPY	2,371	0	2,371	0	59
66.00	06600	PHYSICAL THERAPY	4,303	0	4,303	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	1,019	0	1,019	0	1
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09500	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	95,247	59,995	90,744	213,522	427
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	605	0	605	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	1,989	0	1,989	0	0
194.03	07953	DISTRICT OFFICE	6,668	0	6,668	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	2,976	0
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,911,812	1,115,428	1,931,561	4,183,991	1,968,025
203.00		Unit cost multiplier (Wkst. B, Part I)	75.704600	18.592016	19.314451	19.325772	4,608.957845
204.00		Cost to be allocated (per Wkst. B, Part II)	2,302,159	251,991	242,470	902,481	523,448
205.00		Unit cost multiplier (Wkst. B, Part II)	22.028332	4.200200	2.424555	4.168542	1,225.873536

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142008

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	291					13.00
14.00	01400	0	3,651,390				14.00
15.00	01500	0	16,825	3,588,981			15.00
16.00	01600	0	2,880	0	314,472,452		16.00
17.00	01700	0	38	0	0	59,995	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	287	30,421	80,405	135,111,786	59,995	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4	846	675	2,833,066	0	50.00
54.00	05400	0	2,289	7,240	6,771,357	0	54.00
60.00	06000	0	6,471	0	21,576,655	0	60.00
65.00	06500	0	1,506	0	48,818,618	0	65.00
66.00	06600	0	834	13	10,405,710	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	3,589,256	0	21,073,366	0	71.00
73.00	07300	0	0	3,500,648	62,933,921	0	73.00
74.00	07400	0	24	0	4,947,973	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09800	0	0	0	0	0	98.00
100.00	10000	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		291	3,651,390	3,588,981	314,472,452	59,995	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00							201.00
202.00		2,906,353	2,155,771	3,242,840	2,675,614	2,191,322	202.00
203.00		9,987.467354	0.590397	0.903555	0.008508	36.525077	203.00
204.00		209,922	792,384	355,642	267,733	118,958	204.00
205.00		721.381443	0.217009	0.099093	0.000851	1.982799	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142008

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

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		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00		4.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	49,665,236		49,665,236	56,209	49,721,445	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,911,856		1,911,856	28,535	1,940,391	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,080,925		1,080,925	0	1,080,925	54.00
60.00	06000 LABORATORY	2,813,392		2,813,392	23,162	2,836,554	60.00
65.00	06500 RESPIRATORY THERAPY	7,120,847	0	7,120,847	0	7,120,847	65.00
66.00	06600 PHYSICAL THERAPY	4,575,268	0	4,575,268	0	4,575,268	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	7,192,499		7,192,499	0	7,192,499	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,471,763		8,471,763	0	8,471,763	73.00
74.00	07400 RENAL DIALYSIS	2,050,985		2,050,985	0	2,050,985	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
100.00	10000 I&R SERVICES - NOT APPRVD. PRGM.	0		0	0	0	100.00
200.00	Subtotal (see instructions)	84,882,771	0	84,882,771	107,906	84,990,677	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	84,882,771	0	84,882,771	107,906	84,990,677	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142008

Period:
From 09/01/2013
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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	135,111,786		135,111,786		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	2,833,066	0	2,833,066	0.674836	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,771,357	0	6,771,357	0.159632	54.00
60.00	06000	LABORATORY	21,576,655	0	21,576,655	0.130391	60.00
65.00	06500	RESPIRATORY THERAPY	48,818,618	0	48,818,618	0.145863	65.00
66.00	06600	PHYSICAL THERAPY	10,405,710	0	10,405,710	0.439688	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	21,073,366	0	21,073,366	0.341308	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,933,921	0	62,933,921	0.134614	73.00
74.00	07400	RENAL DIALYSIS	4,947,973	0	4,947,973	0.414510	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)	314,472,452	0	314,472,452		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	314,472,452	0	314,472,452		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet C Part I Date/Time Prepared: 1/26/2015 10:59 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	0.684909		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.159632		54.00
60.00	06000 LABORATORY	0.131464		60.00
65.00	06500 RESPIRATORY THERAPY	0.145863		65.00
66.00	06600 PHYSICAL THERAPY	0.439688		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	0.341308		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.134614		73.00
74.00	07400 RENAL DIALYSIS	0.414510		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: 142008

Period:
From 09/01/2013
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		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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	49,665,236		49,665,236	56,209	49,721,445	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,911,856		1,911,856	28,535	1,940,391	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,080,925		1,080,925	0	1,080,925	54.00
60.00	06000 LABORATORY	2,813,392		2,813,392	23,162	2,836,554	60.00
65.00	06500 RESPIRATORY THERAPY	7,120,847	0	7,120,847	0	7,120,847	65.00
66.00	06600 PHYSICAL THERAPY	4,575,268	0	4,575,268	0	4,575,268	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	7,192,499		7,192,499	0	7,192,499	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,471,763		8,471,763	0	8,471,763	73.00
74.00	07400 RENAL DIALYSIS	2,050,985		2,050,985	0	2,050,985	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
100.00	10000 I&R SERVICES - NOT APPRVD. PRGM.	0		0	0	0	100.00
200.00	Subtotal (see instructions)	84,882,771	0	84,882,771	107,906	84,990,677	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	84,882,771	0	84,882,771	107,906	84,990,677	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142008

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		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	135,111,786		135,111,786		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	2,833,066	0	2,833,066	0.674836	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,771,357	0	6,771,357	0.159632	54.00
60.00	06000	LABORATORY	21,576,655	0	21,576,655	0.130391	60.00
65.00	06500	RESPIRATORY THERAPY	48,818,618	0	48,818,618	0.145863	65.00
66.00	06600	PHYSICAL THERAPY	10,405,710	0	10,405,710	0.439688	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	21,073,366	0	21,073,366	0.341308	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,933,921	0	62,933,921	0.134614	73.00
74.00	07400	RENAL DIALYSIS	4,947,973	0	4,947,973	0.414510	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)	314,472,452	0	314,472,452		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	314,472,452	0	314,472,452		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet C Part I Date/Time Prepared: 1/26/2015 10:59 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
44.00	04400 SKILLED NURSING FACILITY			44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
100.00	10000 I&R SERVICES - NOT APPRVD. PRGM.			100.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 142008		Period: From 09/01/2013 To 08/31/2014		Worksheet D Part I Date/Time Prepared: 1/26/2015 10:59 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	7,229,533	0	7,229,533	59,995	120.50	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)	7,229,533		7,229,533	59,995		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	15,703	1,892,212				
31.00	INTENSIVE CARE UNIT	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (Lines 30-199)	15,703	1,892,212				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet D Part II Date/Time Prepared: 1/26/2015 10:59 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	613,942	2,833,066	0.216706	1,046,784	226,844	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	239,954	6,771,357	0.035437	2,054,904	72,820	54.00
60.00	06000 LABORATORY	316,475	21,576,655	0.014667	7,042,357	103,290	60.00
65.00	06500 RESPIRATORY THERAPY	513,484	48,818,618	0.010518	14,455,254	152,040	65.00
66.00	06600 PHYSICAL THERAPY	514,945	10,405,710	0.049487	3,319,312	164,263	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	897,461	21,073,366	0.042587	6,233,916	265,484	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	498,590	62,933,921	0.007922	17,620,037	139,586	73.00
74.00	07400 RENAL DIALYSIS	145,246	4,947,973	0.029355	1,734,956	50,930	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (Lines 50-199)	3,740,097	179,360,666		53,507,520	1,175,257	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142008		Period: From 09/01/2013 To 08/31/2014		Worksheet D Part III Date/Time Prepared: 1/26/2015 10:59 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	59,995	0.00	15,703	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)	59,995		15,703	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142008

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

Worksheet D
Part IV
Date/Time Prepared:
1/26/2015 10:59 am

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet D Part IV Date/Time Prepared: 1/26/2015 10:59 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	2,833,066	0.000000	0.000000	1,046,784	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	6,771,357	0.000000	0.000000	2,054,904	54.00
60.00	06000 LABORATORY	0	21,576,655	0.000000	0.000000	7,042,357	60.00
65.00	06500 RESPIRATORY THERAPY	0	48,818,618	0.000000	0.000000	14,455,254	65.00
66.00	06600 PHYSICAL THERAPY	0	10,405,710	0.000000	0.000000	3,319,312	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	21,073,366	0.000000	0.000000	6,233,916	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	62,933,921	0.000000	0.000000	17,620,037	73.00
74.00	07400 RENAL DIALYSIS	0	4,947,973	0.000000	0.000000	1,734,956	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00	Total (Lines 50-199)	0	179,360,666			53,507,520	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet D Part IV Date/Time Prepared: 1/26/2015 10:59 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XVIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00	Total (Lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet D Part V Date/Time Prepared: 1/26/2015 10:59 am
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.674836	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.159632	0	595,358	0	54.00
60.00	06000 LABORATORY	0.130391	0	41,037	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.145863	0	429,883	0	65.00
66.00	06600 PHYSICAL THERAPY	0.439688	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341308	0	154,862	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.134614	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.414510	0	877,772	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.000000	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.000000		0		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	98.00
200.00	Subtotal (see instructions)		0	2,098,912	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	2,098,912	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet D Part V Date/Time Prepared: 1/26/2015 10:59 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		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	95,038	0	54.00
60.00	06000 LABORATORY	5,351	0	60.00
65.00	06500 RESPIRATORY THERAPY	62,704	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	52,856	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	363,845	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00	Subtotal (see instructions)	579,794	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	579,794	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 1/26/2015 10:59 am
Cost Center Description		PPS		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	59,995		1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	59,995		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)	59,995		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)	15,703		9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0		10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0		11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0		12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0		13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0		14.00
15.00	Total nursery days (title V or XIX only)	0		15.00
16.00	Nursery days (title V or XIX only)	0		16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00		19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00		20.00
21.00	Total general inpatient routine service cost (see instructions)	49,721,445		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)	49,721,445		27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0		28.00
29.00	Private room charges (excluding swing-bed charges)	0		29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0		30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000		31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00		32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00		33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	0.00		34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00		35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0		36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	49,721,445		37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	828.76		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	13,014,018		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)	13,014,018		41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142008		Period: From 09/01/2013 To 08/31/2014		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 1/26/2015 10:59 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)					10,757,491	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					23,771,509	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)					1,892,212	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,175,257	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					3,067,469	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					20,704,040	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: 142008		Period: From 09/01/2013 To 08/31/2014		Worksheet D-1 Date/Time Prepared: 1/26/2015 10:59 am	
		Title XVIII		Hospital		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	7,229,533	49,721,445	0.145401	0	0	90.00
91.00	Nursing School cost	0	49,721,445	0.000000	0	0	91.00
92.00	Allied health cost	0	49,721,445	0.000000	0	0	92.00
93.00	All other Medical Education	0	49,721,445	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 1/26/2015 10:59 am
Cost Center Description		Cost		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	59,995	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	59,995	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)	59,995	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)	30,807	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00	
15.00	Total nursery days (title V or XIX only)	0	15.00	
16.00	Nursery days (title V or XIX only)	0	16.00	
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00	
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00	
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00	
21.00	Total general inpatient routine service cost (see instructions)	49,665,236	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)	49,665,236	27.00	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00	
29.00	Private room charges (excluding swing-bed charges)	0	29.00	
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00	
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	0.00	34.00	
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	49,665,236	37.00	
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	827.82	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)	25,502,651	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)	25,502,651	41.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142008		Period: From 09/01/2013 To 08/31/2014		Worksheet D-1	
Date/Time Prepared: 1/26/2015 10:59 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)					15,890,848		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					41,393,499		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: 142008		Period: From 09/01/2013 To 08/31/2014		Worksheet D-1 Date/Time Prepared: 1/26/2015 10:59 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	7,229,533	49,665,236	0.145565	0	0	90.00
91.00	Nursing School cost	0	49,665,236	0.000000	0	0	91.00
92.00	Allied health cost	0	49,665,236	0.000000	0	0	92.00
93.00	All other Medical Education	0	49,665,236	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142008

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

Worksheet D-2

Date/Time Prepared:
1/26/2015 10:59 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															
PART I - NOT IN APPROVED TEACHING PROGRAM																				
Hospital Inpatient Routine Services:																				
1.00 Total cost of services rendered	0.00	0				1.00														
2.00 ADULTS & PEDIATRICS	0.00	0	59,995	0.00	0	2.00														
3.00 INTENSIVE CARE UNIT	0.00	0	0	0.00	0	3.00														
4.00 CORONARY CARE UNIT						4.00														
5.00 BURN INTENSIVE CARE UNIT						5.00														
6.00 SURGICAL INTENSIVE CARE UNIT						6.00														
7.00 OTHER SPECIAL CARE (SPECIFY)						7.00														
8.00 NURSERY						8.00														
9.00 Subtotal (sum of lines 2 through 8)	0.00	0				9.00														
10.00 SUBPROVIDER - IPF						10.00														
11.00 SUBPROVIDER - IRF						11.00														
12.00 SUBPROVIDER						12.00														
13.00 SKILLED NURSING FACILITY	0.00	0	0	0.00	0	13.00														
14.00 NURSING FACILITY						14.00														
15.00 OTHER LONG TERM CARE						15.00														
16.00 HOME HEALTH AGENCY						16.00														
17.00 CMHC						17.00														
18.00 AMBULATORY SURGICAL CENTER (D.P.)						18.00														
19.00 HOSPICE						19.00														
20.00 Subtotal (sum of lines 9 through 19)	0.00	0				20.00														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th></th> <th></th> <th>Total Charges (from Worksheet C. Part I, column 8, lines 88 through 93)</th> <th>Ratio of Cost to Charges (col. 2 ÷ col. 3)</th> <th>Titles V and XIX Outpatient and Title XVIII Part B Charges Title V</th> <th></th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td> </tr> </thead> </table>							Cost Center Description			Total Charges (from Worksheet C. Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V			1.00	2.00	3.00	4.00	5.00	
Cost Center Description			Total Charges (from Worksheet C. Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V															
	1.00	2.00	3.00	4.00	5.00															
Hospital Outpatient Services:																				
21.00 RURAL HEALTH CLINIC						21.00														
22.00 FEDERALLY QUALIFIED HEALTH CENTER						22.00														
23.00 CLINIC	0.00	0	0	0.000000	0	23.00														
24.00 EMERGENCY	0.00	0	0	0.000000	0	24.00														
25.00 OBSERVATION BEDS (NON-DISTINCT PART)						25.00														
26.00 OTHER OUTPATIENT SERVICE COST CENTER						26.00														
27.00 Subtotal (sum of lines 21 through 26)	0.00	0				27.00														
28.00 Total (sum of lines 20 and 27)	0.00	0				28.00														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th>Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22</th> <th>Swing bed Amount</th> <th>Net cost (column 1 plus column 2)</th> <th>Total Inpatient Days - All Patients</th> <th>Average Cost Per Day (col. 3 ÷ col. 4)</th> <th></th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td> </tr> </thead> </table>							Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)			1.00	2.00	3.00	4.00	5.00	
Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)															
	1.00	2.00	3.00	4.00	5.00															
PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)																				
Hospital Inpatient Routine Services:																				
29.00 ADULTS & PEDIATRICS	0	0	0	59,995	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: 142008

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

Worksheet D-2

Date/Time Prepared:
1/26/2015 10:59 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	
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)				
Hospital				
43.00 Inpatient	col. 9, line 9.00		0 line 37.00	43.00
44.00 Outpatient	col. 9, line 27.00		0	44.00
45.00 Total Hospital (sum of lines 43 and 44)			0	45.00
46.00 SUBPROVIDER - IPF				46.00
47.00 SUBPROVIDER - IRF				47.00
48.00 SUBPROVIDER				48.00
49.00 SKILLED NURSING FACILITY	col. 9, line 13.00		0 col. 9, line 41.00	49.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142008

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

Worksheet D-2
Date/Time Prepared:
1/26/2015 10:59 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					
PART I - NOT IN APPROVED TEACHING PROGRAM							
1.00	Total cost of services rendered					1.00	
Hospital Inpatient Routine Services:							
2.00	ADULTS & PEDIATRICS	15,703	30,807	0	0	0	2.00
3.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	CORONARY CARE UNIT						4.00
5.00	BURN INTENSIVE CARE UNIT						5.00
6.00	SURGICAL INTENSIVE CARE UNIT						6.00
7.00	OTHER SPECIAL CARE (SPECIFY)						7.00
8.00	NURSERY						8.00
9.00	Subtotal (sum of lines 2 through 8)			0	0	0	9.00
10.00	SUBPROVIDER - IPF						10.00
11.00	SUBPROVIDER - IRF						11.00
12.00	SUBPROVIDER						12.00
13.00	SKILLED NURSING FACILITY	0	0	0	0	0	13.00
14.00	NURSING FACILITY						14.00
15.00	OTHER LONG TERM CARE						15.00
16.00	HOME HEALTH AGENCY						16.00
17.00	CMHC						17.00
18.00	AMBULATORY SURGICAL CENTER (D.P.)						18.00
19.00	HOSPICE						19.00
20.00	Subtotal (sum of lines 9 through 19)						20.00
Cost Center Description		Titles V and XIX Outpatient and Title XVIII Part B Charges		Titles V and XIX Outpatient and Title XVIII Part B Cost			
		Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
Hospital Outpatient Services:							
21.00	RURAL HEALTH CLINIC						21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER						22.00
23.00	CLINIC	0	0	0	0	0	23.00
24.00	EMERGENCY	0	0	0	0	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)						25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER						26.00
27.00	Subtotal (sum of lines 21 through 26)			0	0	0	27.00
28.00	Total (sum of lines 20 and 27)						28.00
Cost Center Description		Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents			
		6.00	7.00	11.00			
PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)							
Hospital Inpatient Routine Services:							
29.00	ADULTS & PEDIATRICS	0	0	0			29.00
30.00	Swing Bed - SNF	0	0				30.00
31.00	Swing Bed - NF						31.00
32.00	INTENSIVE CARE UNIT	0	0	0			32.00
33.00	CORONARY CARE UNIT						33.00
34.00	BURN INTENSIVE CARE UNIT						34.00
35.00	SURGICAL INTENSIVE CARE UNIT						35.00
36.00	OTHER SPECIAL CARE (SPECIFY)						36.00
37.00	Subtotal (sum of lines 28, and 29 through 36)		0	0			37.00
38.00	SUBPROVIDER - IPF						38.00
39.00	SUBPROVIDER - IRF						39.00
40.00	SUBPROVIDER						40.00
41.00	SKILLED NURSING FACILITY	0	0	0			41.00
42.00	Total (sum of lines 37 through 41)		0	0			42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142008

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

Worksheet D-2

Date/Time Prepared:
1/26/2015 10:59 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		
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)					
Hospital					
43.00	Inpatient	0		0	43.00
44.00	Outpatient				44.00
45.00	Total Hospital (sum of lines 43 and 44)	0	line 2.00	0	45.00
46.00	SUBPROVIDER - IPF				46.00
47.00	SUBPROVIDER - IRF				47.00
48.00	SUBPROVIDER				48.00
49.00	SKILLED NURSING FACILITY	0	line 2.00	0	49.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet D-3 Date/Time Prepared: 1/26/2015 10:59 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		36,281,462		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.684909	1,046,784	716,952	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.159632	2,054,904	328,028	54.00
60.00	06000 LABORATORY	0.131464	7,042,357	925,816	60.00
65.00	06500 RESPIRATORY THERAPY	0.145863	14,455,254	2,108,487	65.00
66.00	06600 PHYSICAL THERAPY	0.439688	3,319,312	1,459,462	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	0.341308	6,233,916	2,127,685	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.134614	17,620,037	2,371,904	73.00
74.00	07400 RENAL DIALYSIS	0.414510	1,734,956	719,157	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)		53,507,520	10,757,491	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)		53,507,520		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet D-3 Date/Time Prepared: 1/26/2015 10:59 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		68,498,412		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.674836	1,283,120	865,896	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.159632	2,468,969	394,126	54.00
60.00	06000 LABORATORY	0.130391	8,062,121	1,051,228	60.00
65.00	06500 RESPIRATORY THERAPY	0.145863	23,459,747	3,421,909	65.00
66.00	06600 PHYSICAL THERAPY	0.439688	4,267,163	1,876,220	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	0.341308	9,889,443	3,375,346	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.134614	32,624,546	4,391,721	73.00
74.00	07400 RENAL DIALYSIS	0.414510	1,240,988	514,402	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)		83,296,097	15,890,848	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)		83,296,097		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet E Part B Date/Time Prepared: 1/26/2015 10:59 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		579,794	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)		579,794	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		2,098,912	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)		2,098,912	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		2,098,912	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,519,118	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)		579,794	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		419,894	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)		159,900	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)		159,900	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		159,900	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		88	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		57	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		51	36.00
37.00	Subtotal (see instructions)		159,957	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)		159,957	40.00
40.01	Sequestration adjustment (see instructions)		3,199	40.01
41.00	Interim payments		105,439	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		51,319	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 142008

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

Worksheet E-1
Part I
Date/Time Prepared:
1/26/2015 10:59 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		24,920,184		105,439	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	08/28/2014	1,102,500		0	3.01
3.02		11/21/2014	150,700		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	10/07/2014	300,000		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)		953,200		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)		25,873,384		105,439	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		14,915		51,319	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		25,888,299		156,758	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: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet E-3 Part IV Date/Time Prepared: 1/26/2015 10:59 am
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		26,453,485	1.00
2.00	Outlier Payments		1,075,659	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		27,529,144	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)		27,529,144	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8)		27,529,144	9.00
10.00	Deductibles		46,912	10.00
11.00	Subtotal (line 9 minus line 10)		27,482,232	11.00
12.00	Coinsurance		2,120,120	12.00
13.00	Subtotal (line 11 minus line 12)		25,362,112	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		1,622,339	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		1,054,520	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,480,257	16.00
17.00	Subtotal (sum of lines 13 and 15)		26,416,632	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)		26,416,632	22.00
22.01	Sequestration adjustment (see instructions)		528,333	22.01
23.00	Interim payments		25,873,384	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)		14,915	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
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: 142008	Period: From 09/01/2013 To 08/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 1/26/2015 10:59 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		41,393,499		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)		41,393,499	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)		41,393,499	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		68,498,412		8.00
9.00	Ancillary service charges		83,296,097	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)		151,794,509	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		151,794,509	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		110,401,010	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)		41,393,499	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		41,393,499	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		41,393,499	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)		41,393,499	0	36.00
37.00	OTHER ADJUSTMENTS		0	0	37.00
37.01	OTHER ADJUSTMENTS		0	0	37.01
38.00	Subtotal (line 36 ± line 37)		41,393,499	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)		41,393,499	0	40.00
41.00	Interim payments		32,489,103	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		8,904,396	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 142008

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

Worksheet G

Date/Time Prepared:
1/26/2015 10:59 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	499,207	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	29,951,107	0	0	0	4.00
5.00	Other receivable	-16,864	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,942,065	0	0	0	6.00
7.00	Inventory	682,296	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)	27,173,681	0	0	0	11.00
FIXED ASSETS						
12.00	Land	675,156	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	31,090	0	0	0	15.00
16.00	Accumulated depreciation	-31,090	0	0	0	16.00
17.00	Leasehold improvements	33,541,798	0	0	0	17.00
18.00	Accumulated depreciation	-29,522,853	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	14,879,017	0	0	0	23.00
24.00	Accumulated depreciation	-11,589,430	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,983,688	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	235,990	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	235,990	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,393,359	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,146,193	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,368,109	0	0	0	38.00
39.00	Payroll taxes payable	79,595	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	2,561,529	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,155,426	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-67,729,573	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-67,729,573	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-60,574,147	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	95,967,506	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	95,967,506	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,393,359	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 142008

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

Worksheet G-1

Date/Time Prepared:
1/26/2015 10:59 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		101,549,462		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-5,581,957			2.00
3.00	Total (sum of line 1 and line 2)		95,967,505		0	3.00
4.00	Additions (credit adjustments)	0		0		4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	1		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)		1		0	10.00
11.00	Subtotal (line 3 plus line 10)		95,967,506		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)		95,967,506		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: 142008

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
1/26/2015 10:59 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	135,111,786		135,111,786	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)	135,111,786		135,111,786	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)	135,111,786		135,111,786	17.00
18.00	Ancillary services	179,360,666	0	179,360,666	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)	314,472,452	0	314,472,452	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		96,471,858		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)		96,471,858		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 142008

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

Worksheet G-3

Date/Time Prepared:
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	314,472,452	1.00
2.00	Less contractual allowances and discounts on patients' accounts	224,058,594	2.00
3.00	Net patient revenues (line 1 minus line 2)	90,413,858	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	96,471,858	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,058,000	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	5,241	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	130,758	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	6,506	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	333,538	24.00
25.00	Total other income (sum of lines 6-24)	476,043	25.00
26.00	Total (line 5 plus line 25)	-5,581,957	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)	-5,581,957	29.00