

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet S Parts I-III Date/Time Prepared: 9/29/2014 11:52 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: 9/29/2014	Time: 11:52 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 Peoria (142013) for the cost reporting period beginning 05/01/2013 and ending 04/30/2014 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	201,238	-1	0	19,205	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00 Total	0	201,238	-1	0	19,205	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142013		Period: From 05/01/2013 To 04/30/2014		Worksheet S-2 Part I Date/Time Prepared: 9/29/2014 11:51 am			
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 500 West Romeo B Garrett Ave.		PO Box:				1.00		
2.00	City: Peoria		State: IL		Zip Code: 61605		County: Peoria		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00 8.00
		V		XVIII		XIX			
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		Kindred Hospital Peoria		142013	37900	2	05/01/2010	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)						05/01/2013	04/30/2014	
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)								
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	
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	
							Urban/Rural	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		
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		
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		

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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 Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	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 a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					Y	80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00		97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			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:	24,371	0	85,340		
		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			141.00	
142.00	Street: 680 SOUTH FOURTH AVENUE	PO Box:					142.00	
143.00	City: LOUISVILLE	State: KY		Zip Code: 40202		143.00		
							1.00	
144.00	Are provider based physicians' costs included in Worksheet A?						Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.						Y	145.00
							1.00	
							2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N	146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N			155.00
156.00	Subprovider - IPF	N	N	N	N			156.00
157.00	Subprovider - IRF	N	N	N	N			157.00
158.00	SUBPROVIDER							158.00
159.00	SNF	N	N	N	N			159.00
160.00	HOME HEALTH AGENCY	N	N	N	N			160.00
161.00	CMHC		N	N	N			161.00
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
166.01							0.00	166.01
166.02							0.00	166.02
166.03							0.00	166.03
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0.00	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
		Beginni ng		Endi ng				
		1.00		2.00				
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet S-2 Part II Date/Time Prepared: 9/29/2014 11:51 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.			Y	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	08/31/2014	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

	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)	08/31/2014		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: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
9/29/2014 11:51 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	50	18,250	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)		50	18,250	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		50	18,250	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
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)		50				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		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: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
9/29/2014 11:51 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,844	10	8,780			1.00
2.00 HMO and other (see instructions)	559	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,844	10	8,780			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	6,844	10	8,780	0.00	99.10	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	99.10	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)						30.00
31.00 Employee discount days - IRF						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	20					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
9/29/2014 11:51 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	260	1	335	1.00
2.00 HMO and other (see instructions)			23			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	260	1	335	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: 142013		Period: From 05/01/2013 To 04/30/2014		Worksheet S-3 Part II Date/Time Prepared: 9/29/2014 11:51 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	5,933,114	0	5,933,114	205,957.00	28.81	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)		347	53,279	53,626	1,409.00	38.06	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		815,193	0	815,193	14,344.00	56.83	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		21,742	0	21,742	143.00	152.04	13.00
14.00	Home office salaries & wage-related costs		569,108	0	569,108	12,647.00	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)		1,002,724	0	1,002,724			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		9,086	0	9,086			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	101,348	0	101,348	4,460.00	22.72	26.00
27.00	Administrative & General	5.00	1,150,739	0	1,150,739	28,614.00	40.22	27.00
28.00	Administrative & General under contract (see inst.)		3,614	0	3,614	59.00	61.25	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	167,681	0	167,681	12,847.00	13.05	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	182,750	0	182,750	12,075.00	15.13	34.00
35.00	Dietary under contract (see instructions)		19,223	0	19,223	959.00	20.04	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	537,388	0	537,388	15,845.00	33.92	38.00
39.00	Central Services and Supply	14.00	49,342	0	49,342	2,731.00	18.07	39.00
40.00	Pharmacy	15.00	326,348	0	326,348	8,154.00	40.02	40.00
41.00	Medical Records & Medical Records Library	16.00	212,973	0	212,973	7,827.00	27.21	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet S-3
Part II
Date/Time Prepared:
9/29/2014 11:51 am

		Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Social Service	17.00	337,798	-53,279	284,519	7,526.00	37.80	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet S-3
Part III
Date/Time Prepared:
9/29/2014 11:51 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)	5,955,951	0	5,955,951	206,975.00	28.78	1.00
2.00	Excluded area salaries (see instructions)	347	53,279	53,626	1,409.00	38.06	2.00
3.00	Subtotal salaries (line 1 minus line 2)	5,955,604	-53,279	5,902,325	205,566.00	28.71	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,406,043	0	1,406,043	27,134.00	51.82	4.00
5.00	Subtotal wage-related costs (see inst.)	1,002,724	0	1,002,724	0.00	16.99	5.00
6.00	Total (sum of lines 3 thru 5)	8,364,371	-53,279	8,311,092	232,700.00	35.72	6.00
7.00	Total overhead cost (see instructions)	3,089,204	-53,279	3,035,925	101,097.00	30.03	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet S-3 Part IV Date/Time Prepared: 9/29/2014 11:51 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	218	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)	266,851	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-3,451	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	3,718	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	21,048	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	163,481	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	413,979	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	105,331	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	31,549	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,002,724	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet A
Date/Time Prepared:
9/29/2014 11:51 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		2,076,129	2,076,129	37,499	2,113,628	1.00
2.00	00200		956,686	956,686	351,996	1,308,682	2.00
3.00	00300		389,495	389,495	-389,495	0	3.00
4.00	00400	101,348	1,097,154	1,198,502	0	1,198,502	4.00
5.00	00500	1,150,739	1,689,638	2,840,377	0	2,840,377	5.00
7.00	00700	0	589,176	589,176	0	589,176	7.00
8.00	00800	0	60,065	60,065	0	60,065	8.00
9.00	00900	167,681	17,862	185,543	0	185,543	9.00
10.00	01000	182,750	190,463	373,213	0	373,213	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	537,388	4,415	541,803	0	541,803	13.00
14.00	01400	49,342	8,981	58,323	0	58,323	14.00
15.00	01500	326,348	18,508	344,856	0	344,856	15.00
16.00	01600	212,973	81,078	294,051	0	294,051	16.00
17.00	01700	337,798	41,054	378,852	-59,754	319,098	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,131,708	1,167,750	3,299,458	1,656	3,301,114	30.00
31.00	03100	0	1,656	1,656	-1,656	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	19,893	159,938	179,831	0	179,831	50.00
54.00	05400	159,313	94,789	254,102	0	254,102	54.00
60.00	06000	0	245,972	245,972	0	245,972	60.00
65.00	06500	555,486	55,708	611,194	0	611,194	65.00
66.00	06600	0	345,293	345,293	0	345,293	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	505,530	505,530	0	505,530	71.00
73.00	07300	0	564,580	564,580	0	564,580	73.00
74.00	07400	0	127,748	127,748	0	127,748	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		5,932,767	10,489,668	16,422,435	-59,754	16,362,681	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	59,754	59,754	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	347	0	347	0	347	194.11
200.00		5,933,114	10,489,668	16,422,782	0	16,422,782	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet A
Date/Time Prepared:
9/29/2014 11:51 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	-30,802	2,082,826	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-36,533	1,272,149	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-603	1,197,899	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	474,659	3,315,036	5.00
7.00	00700	OPERATION OF PLANT	-532	588,644	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	60,065	8.00
9.00	00900	HOUSEKEEPING	0	185,543	9.00
10.00	01000	DIETARY	-22,694	350,519	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	541,803	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	58,323	14.00
15.00	01500	PHARMACY	0	344,856	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,916	291,135	16.00
17.00	01700	SOCIAL SERVICE	0	319,098	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-213,025	3,088,089	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	179,831	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	254,102	54.00
60.00	06000	LABORATORY	0	245,972	60.00
65.00	06500	RESPIRATORY THERAPY	0	611,194	65.00
66.00	06600	PHYSICAL THERAPY	0	345,293	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	505,530	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	564,580	73.00
74.00	07400	RENAL DIALYSIS	0	127,748	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)	167,554	16,530,235	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	59,754	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	347	194.11
200.00		TOTAL (SUM OF LINES 118-199)	167,554	16,590,336	200.00

RECLASSIFICATIONS

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-6

Date/Time Prepared:
9/29/2014 11:51 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	53,279	6,475	1.00
	TOTALS			53,279	6,475	
C - RECLASS ICU EXPENSE TO ROUTINE						
1.00	ADULTS & PEDIATRICS		30.00	0	1,656	1.00
	TOTALS			0	1,656	
500.00	Grand Total: Increases			53,279	8,131	500.00

RECLASSIFICATIONS

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-6

Date/Time Prepared:
9/29/2014 11:51 am

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - RECLASS NON ALLOWABLE CASE MANAGER							
1.00	SOCIAL SERVICE	17.00	53,279	6,475	0		1.00
	TOTALS		53,279	6,475			
C - RECLASS ICU EXPENSE TO ROUTINE							
1.00	INTENSIVE CARE UNIT	31.00	0	1,656	0		1.00
	TOTALS		0	1,656			
500.00	Grand Total: Decreases		53,279	8,131			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-7
Part I
Date/Time Prepared:
9/29/2014 11:51 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	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	322,480	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	2,960,991	66,059	0	66,059	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	3,283,471	66,059	0	66,059	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	3,283,471	66,059	0	66,059	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	322,480	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	3,027,050	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	3,349,530	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	3,349,530	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-7
Part II
Date/Time Prepared:
9/29/2014 11:51 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	55,513	2,020,616	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	629,436	327,250	0	0	0	2.00
3.00	Total (sum of lines 1-2)	684,949	2,347,866	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	2,076,129				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	956,686				2.00
3.00	Total (sum of lines 1-2)	0	3,032,815				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-7
Part III
Date/Time Prepared:
9/29/2014 11:51 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	322,480	0	322,480	0.096276	2,660	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,027,050	0	3,027,050	0.903724	24,971	2.00
3.00	Total (sum of lines 1-2)	3,349,530	0	3,349,530	1.000000	27,631	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	34,839	0	37,499	29,546	2,020,616	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	327,025	0	351,996	592,903	327,250	2.00
3.00	Total (sum of lines 1-2)	361,864	0	389,495	622,449	2,347,866	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	-2,175	34,839	0	2,082,826	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	24,971	327,025	0	1,272,149	2.00
3.00	Total (sum of lines 1-2)	0	22,796	361,864	0	3,354,975	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-8

Date/Time Prepared:
9/29/2014 11:51 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)	B	-212		ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-896		ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-7,958		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-532		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	-206,290				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	953,919				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-22,493		DIETARY	10.00	0	14.00
15.00 Rental of quarters to employee and others		0			0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00 Sale of drugs to other than patients		0			0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-2,916		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00 Vending machines	B	-201		DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0		CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0		CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0		*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0			0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0		OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0		ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0		SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00		0			0.00	0	33.00
33.01 MISCELLANEOUS INCOME	B	-497,137		ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-8

Date/Time Prepared:
9/29/2014 11:51 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
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		0		0.00	0	33.05
33.06	PATIENT PERSONAL SERVICES EXPENSE	-24	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PROFESSIONAL FEES - CAPITAL PROJECT	10,216	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MEDICARE BAD DEBT - PART A	-300,633	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09		0		0.00	0	33.09
33.10	OTHER MEDICARE NON ALLOWABLE	-3,541	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	-1,257	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	OTHER OPERATING - PUBLIC RELATIONS	-210	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	OTHER OPERATING - MARKETING	-6,660	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OTHER OPERATING - INTEREST	-8	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15		0		0.00	0	33.15
33.16		0		0.00	0	33.16
33.17		0		0.00	0	33.17
33.18	OTHER OPERATING - COMMUNITY EVENTS	-250	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19		0		0.00	0	33.19
33.20	OTHER OPERATING - TRADE SHOW BOOTH	188	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21		0		0.00	0	33.21
33.22		0		0.00	0	33.22
33.23	CHARITABLE CONTRIBUTIONS	-5,033	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24		0		0.00	0	33.24
33.25		0		0.00	0	33.25
33.26		0		0.00	0	33.26
33.27		0		0.00	0	33.27
33.28	AGGREGATE CAPITAL EROSION	-5,148	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	CABLE TV AND SATELLITE	-4,327	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	VENDING MACHINE	477	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	MARKETING BONUS	-1,803	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32		0		0.00	0	33.32
33.33		0		0.00	0	33.33
33.34	MALPRACTICE TAIL LIABILITY	18,810	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	AGGREGATE CAP PYMT-NONALLOWABLE	15,771	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36		0		0.00	0	33.36
33.37	PHYSICIAN BILLING COLLECTION FEES	-12,836	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	-25,967	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
34.01	MEDICARE VS BOOK MOV EQUIP	-60,456	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.01
34.02		0		0.00	0	34.02
34.03	ASSET ADD-ON MOV EQUIP	23,923	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.03
34.04	MSA MGMT FEE REV ADD-BACK	480,871	ADMINISTRATIVE & GENERAL	5.00	0	34.04
34.05	MSA MGMT FEE EXP OFFSET	-482,911	ADMINISTRATIVE & GENERAL	5.00	0	34.05
34.06	NON ALLOWABLE LOBBYING FEES	-4,792	ADMINISTRATIVE & GENERAL	5.00	0	34.06
34.07	OTHER NONALLOW DUES & SUBSCRIPTIONS	-775	ADMINISTRATIVE & GENERAL	5.00	0	34.07
34.08	BUSINESS INTERRUPTION INS PREMIUM	-4,835	CAP REL COSTS-BLDG & FIXT	1.00	12	34.08
34.09		0		0.00	0	34.09
34.10		0		0.00	0	34.10
34.11		0		0.00	0	34.11
34.12		0		0.00	0	34.12
34.13		0		0.00	0	34.13
34.14		0		0.00	0	34.14
34.15	DEFERRED PRE OPENING COSTS	363,175	ADMINISTRATIVE & GENERAL	5.00	0	34.15
34.16		0		0.00	0	34.16
34.17		0		0.00	0	34.17
34.18		0		0.00	0	34.18
34.19		0		0.00	0	34.19

Provider CCN: 142013

Period:
 From 05/01/2013
 To 04/30/2014

Worksheet A-8

Date/Time Prepared:
 9/29/2014 11:51 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	4.00
34.20		0			0.00	0	34.20
34.21		0			0.00	0	34.21
34.22	A	-5,460	ADMINISTRATIVE & GENERAL		5.00	0	34.22
34.23	A	-603	EMPLOYEE BENEFITS		4.00	0	34.23
34.24		0			0.00	0	34.24
34.25	A	-6,735	ADULTS & PEDIATRICS		30.00	0	34.25
34.26	A	-26,897	ADMINISTRATIVE & GENERAL		5.00	0	34.26
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		0			0.00	0	35.06
35.07		0			0.00	0	35.07
35.08		0			0.00	0	35.08
35.09		0			0.00	0	35.09
35.10		0			0.00	0	35.10
35.11		0			0.00	0	35.11
35.12		0			0.00	0	35.12
35.13		0			0.00	0	35.13
35.14		0			0.00	0	35.14
35.15		0			0.00	0	35.15
35.16		0			0.00	0	35.16
35.17		0			0.00	0	35.17
35.18		0			0.00	0	35.18
35.19		0			0.00	0	35.19
35.20		0			0.00	0	35.20
35.21		0			0.00	0	35.21
35.22		0			0.00	0	35.22
35.23		0			0.00	0	35.23
35.24		0			0.00	0	35.24
35.25		0			0.00	0	35.25
50.00		167,554					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: 142013
 Period: From 05/01/2013 To 04/30/2014
 Worksheet A-8-1
 Date/Time Prepared: 9/29/2014 11:51 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	953,919	0
2.00	4.00	EMPLOYEE BENEFITS	Workers Comp Premium	171,594	171,594
3.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	92,810	92,810
4.00	0.00			0	0
4.01	0.00			0	0
4.02	0.00			0	0
4.03	0.00			0	0
4.04	0.00			0	0
4.05	0.00			0	0
5.00	0	0	0	1,218,323	264,404

* 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			0.00		0.00	10.00
10.01			0.00		0.00	10.01
10.02			0.00		0.00	10.02
10.03			0.00		0.00	10.03
10.04			0.00		0.00	10.04
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-8-1

Date/Time Prepared:
9/29/2014 11:51 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	953,919	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
5.00	953,919			5.00

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

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

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

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

6.00	HomeOffice Cost		6.00
7.00	Worker Comp Ins		7.00
8.00	Liability Insur		8.00
9.00			9.00
10.00			10.00
10.01			10.01
10.02			10.02
10.03			10.03
10.04			10.04
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-8-2

Date/Time Prepared:
9/29/2014 11:51 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	30.00	DR. B	6,440	0	6,440	171,400	43	2.00
3.00	30.00	DR. C	84,869	84,869	0	171,400	0	3.00
4.00	30.00	DR. D	7,529	7,529	0	171,400	0	4.00
5.00	30.00	DR. E	90,100	90,100	0	171,400	0	5.00
6.00	30.00	DR. F	5,894	5,894	0	171,400	0	6.00
7.00	30.00	DR. G	15,001	15,001	0	171,400	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			209,833	203,393	6,440		43	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	30.00	DR. B	3,543	177	0	0	0	2.00
3.00	30.00	DR. C	0	0	0	0	0	3.00
4.00	30.00	DR. D	0	0	0	0	0	4.00
5.00	30.00	DR. E	0	0	0	0	0	5.00
6.00	30.00	DR. F	0	0	0	0	0	6.00
7.00	30.00	DR. G	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,543	177	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	0.00		0	0	0	0	1.00
2.00	30.00	DR. B	0	3,543	2,897	2,897	2.00
3.00	30.00	DR. C	0	0	0	84,869	3.00
4.00	30.00	DR. D	0	0	0	7,529	4.00
5.00	30.00	DR. E	0	0	0	90,100	5.00
6.00	30.00	DR. F	0	0	0	5,894	6.00
7.00	30.00	DR. G	0	0	0	15,001	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	3,543	2,897	206,290	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142013

Period: From 05/01/2013 To 04/30/2014

Worksheet B Part I Date/Time Prepared: 9/29/2014 11:51 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	2,082,826	2,082,826			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,272,149		1,272,149		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,197,899	10,646	6,571	1,215,116	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,315,036	85,169	52,570	239,770	5.00
7.00 00700	OPERATION OF PLANT	588,644	240,276	148,309	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	60,065	0	0	0	8.00
9.00 00900	HOUSEKEEPING	185,543	32,973	20,353	34,938	9.00
10.00 01000	DIETARY	350,519	120,064	74,109	38,078	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	541,803	18,039	11,135	111,971	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	58,323	55,448	34,225	10,281	14.00
15.00 01500	PHARMACY	344,856	29,388	18,139	67,999	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	291,135	30,127	18,596	44,375	16.00
17.00 01700	SOCIAL SERVICE	319,098	0	0	59,283	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,088,089	993,451	613,201	444,166	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	179,831	0	0	4,145	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	254,102	36,448	22,497	33,195	54.00
60.00 06000	LABORATORY	245,972	9,020	5,567	0	60.00
65.00 06500	RESPIRATORY THERAPY	611,194	17,928	11,066	115,742	65.00
66.00 06600	PHYSICAL THERAPY	345,293	382,039	235,811	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	505,530	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	564,580	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	127,748	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
100.00 10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	16,530,235	2,061,016	1,272,149	1,203,943	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CASE MANAGER	59,754	21,810	0	11,101	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07 07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	347	0	0	72	194.11
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	16,590,336	2,082,826	1,272,149	1,215,116	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet B Part I Date/Time Prepared: 9/29/2014 11:51 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	3,692,545				5.00
7.00	00700	OPERATION OF PLANT	279,774	1,257,003			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,196	0	77,261		8.00
9.00	00900	HOUSEKEEPING	78,389	24,029	0	376,225	9.00
10.00	01000	DIETARY	166,843	87,494	0	26,698	863,805
11.00	01100	CAFETERIA	0	0	0	0	380,695
13.00	01300	NURSING ADMINISTRATION	195,523	13,146	0	4,011	0
14.00	01400	CENTRAL SERVICES & SUPPLY	45,314	40,407	0	12,330	0
15.00	01500	PHARMACY	131,804	21,416	0	6,535	0
16.00	01600	MEDICAL RECORDS & LIBRARY	110,003	21,954	0	6,699	0
17.00	01700	SOCIAL SERVICE	108,328	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,471,232	723,955	77,261	220,903	427,042
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	52,671	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,127	26,561	0	8,105	0
60.00	06000	LABORATORY	74,596	6,573	0	2,006	0
65.00	06500	RESPIRATORY THERAPY	216,417	13,065	0	3,987	0
66.00	06600	PHYSICAL THERAPY	275,741	278,403	0	84,951	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	144,730	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	161,635	0	0	0	0
74.00	07400	RENAL DIALYSIS	36,573	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	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)	3,665,896	1,257,003	77,261	376,225	807,737
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	26,529	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0	0
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09	07958	VISITOR MEALS	0	0	0	0	56,068
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	120	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,692,545	1,257,003	77,261	376,225	863,805

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 142013		Period: From 05/01/2013 To 04/30/2014		Worksheet B Part I Date/Time Prepared: 9/29/2014 11:51 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	380,695					11.00
13.00	01300	42,895	938,523				13.00
14.00	01400	5,362	0	261,690			14.00
15.00	01500	21,448	0	3,117	644,702		15.00
16.00	01600	21,448	0	33	0	544,370	16.00
17.00	01700	21,448	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	203,751	938,523	39,786	0	227,137	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	7,199	50.00
54.00	05400	10,724	0	384	0	14,388	54.00
60.00	06000	0	0	0	0	29,064	60.00
65.00	06500	53,619	0	13,033	0	87,794	65.00
66.00	06600	0	0	222	0	20,863	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	205,115	0	56,318	71.00
73.00	07300	0	0	0	644,702	95,320	73.00
74.00	07400	0	0	0	0	6,287	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		380,695	938,523	261,690	644,702	544,370	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		380,695	938,523	261,690	644,702	544,370	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142013

Period:
From 05/01/2013
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400					14.00
15.00	01500					15.00
16.00	01600					16.00
17.00	01700	508,157				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	508,157	9,976,654	0	9,976,654	30.00
31.00	03100	0	0	0	0	31.00
44.00	04400	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	243,846	0	243,846	50.00
54.00	05400	0	505,531	0	505,531	54.00
60.00	06000	0	372,798	0	372,798	60.00
65.00	06500	0	1,143,845	0	1,143,845	65.00
66.00	06600	0	1,623,323	0	1,623,323	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
71.00	07100	0	911,693	0	911,693	71.00
73.00	07300	0	1,466,237	0	1,466,237	73.00
74.00	07400	0	170,608	0	170,608	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	0	0	0	0	90.00
91.00	09100	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	0	0	0	0	95.00
98.00	09500	0	0	0	0	98.00
100.00	10000	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00		508,157	16,414,535	0	16,414,535	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
194.00	07950	0	119,194	0	119,194	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
194.03	07953	0	0	0	0	194.03
194.04	07954	0	0	0	0	194.04
194.05	07955	0	0	0	0	194.05
194.06	07956	0	0	0	0	194.06
194.07	07957	0	0	0	0	194.07
194.08	07959	0	0	0	0	194.08
194.09	07958	0	56,068	0	56,068	194.09
194.10	07962	0	0	0	0	194.10
194.11	07961	0	539	0	539	194.11
200.00		0	0	0	0	200.00
201.00		0	0	0	0	201.00
202.00		508,157	16,590,336	0	16,590,336	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet B
Part II
Date/Time Prepared:
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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	10,646	6,571	17,217	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	114,454	85,169	52,570	252,193	5.00
7.00 00700	OPERATION OF PLANT	0	240,276	148,309	388,585	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	32,973	20,353	53,326	9.00
10.00 01000	DIETARY	0	120,064	74,109	194,173	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	18,039	11,135	29,174	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	55,448	34,225	89,673	14.00
15.00 01500	PHARMACY	0	29,388	18,139	47,527	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	30,127	18,596	48,723	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	993,451	613,201	1,606,652	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	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	36,448	22,497	58,945	54.00
60.00 06000	LABORATORY	0	9,020	5,567	14,587	60.00
65.00 06500	RESPIRATORY THERAPY	0	17,928	11,066	28,994	65.00
66.00 06600	PHYSICAL THERAPY	0	382,039	235,811	617,850	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
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)	114,454	2,061,016	1,272,149	3,447,619	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CASE MANAGER	0	21,810	0	21,810	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07 07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	114,454	2,082,826	1,272,149	3,469,429	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet B Part II Date/Time Prepared: 9/29/2014 11:51 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	255,590			5.00
7.00	00700	OPERATION OF PLANT	19,366	407,951		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,190	0	1,190	8.00
9.00	00900	HOUSEKEEPING	5,426	7,798	0	67,045
10.00	01000	DIETARY	11,549	28,396	0	4,758
11.00	01100	CAFETERIA	0	0	0	105,515
13.00	01300	NURSING ADMINISTRATION	13,534	4,266	0	715
14.00	01400	CENTRAL SERVICES & SUPPLY	3,137	13,114	0	2,197
15.00	01500	PHARMACY	9,123	6,950	0	1,165
16.00	01600	MEDICAL RECORDS & LIBRARY	7,614	7,125	0	1,194
17.00	01700	SOCIAL SERVICE	7,498	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	101,834	234,955	1,190	39,366
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,646	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,861	8,620	0	1,444
60.00	06000	LABORATORY	5,163	2,133	0	357
65.00	06500	RESPIRATORY THERAPY	14,980	4,240	0	710
66.00	06600	PHYSICAL THERAPY	19,087	90,354	0	15,139
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,018	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	11,188	0	0	0
74.00	07400	RENAL DIALYSIS	2,532	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	253,746	407,951	1,190	67,045
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	1,836	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0
194.09	07958	VISITOR MEALS	0	0	0	15,540
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	8	0	0	0
200.00		Cross Foot Adjustments				
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	255,590	407,951	1,190	67,045

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142013		Period: From 05/01/2013 To 04/30/2014		Worksheet B Part II Date/Time Prepared: 9/29/2014 11:51 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	105,515					11.00
13.00	01300	11,889	61,164				13.00
14.00	01400	1,486	0	109,753			14.00
15.00	01500	5,945	0	1,307	72,980		15.00
16.00	01600	5,945	0	14	0	71,244	16.00
17.00	01700	5,945	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	56,472	61,164	16,686	0	29,737	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	942	50.00
54.00	05400	2,972	0	161	0	1,882	54.00
60.00	06000	0	0	0	0	3,803	60.00
65.00	06500	14,861	0	5,466	0	11,487	65.00
66.00	06600	0	0	93	0	2,730	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	86,026	0	7,369	71.00
73.00	07300	0	0	0	72,980	12,471	73.00
74.00	07400	0	0	0	0	823	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		105,515	61,164	109,753	72,980	71,244	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		105,515	61,164	109,753	72,980	71,244	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet B Part II Date/Time Prepared: 9/29/2014 11:51 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	14,283			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,283	2,286,994	0	2,286,994
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,647	0	4,647
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	81,355	0	81,355
60.00	06000	LABORATORY	0	26,043	0	26,043
65.00	06500	RESPIRATORY THERAPY	0	82,378	0	82,378
66.00	06600	PHYSICAL THERAPY	0	745,253	0	745,253
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	103,413	0	103,413
73.00	07300	DRUGS CHARGED TO PATIENTS	0	96,639	0	96,639
74.00	07400	RENAL DIALYSIS	0	3,355	0	3,355
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,283	3,430,077	0	3,430,077
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	0	23,803	0	23,803
194.01	07951	IDLE SPACE	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0
194.09	07958	VISITOR MEALS	0	15,540	0	15,540
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	9	0	9
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	14,283	3,469,429	0	3,469,429

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet B-1

Date/Time Prepared:
9/29/2014 11:51 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	56,345				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		55,755			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	288	288	5,831,766		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,304	2,304	1,150,739	-3,692,545	12,897,791
7.00 00700	OPERATION OF PLANT	6,500	6,500	0	0	977,229
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	60,065
9.00 00900	HOUSEKEEPING	892	892	167,681	0	273,807
10.00 01000	DIETARY	3,248	3,248	182,750	0	582,770
11.00 01100	CAFETERIA	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	488	488	537,388	0	682,948
14.00 01400	CENTRAL SERVICES & SUPPLY	1,500	1,500	49,342	0	158,277
15.00 01500	PHARMACY	795	795	326,348	0	460,382
16.00 01600	MEDICAL RECORDS & LIBRARY	815	815	212,973	0	384,233
17.00 01700	SOCIAL SERVICE	0	0	284,519	0	378,381
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	26,875	26,875	2,131,708	0	5,138,907
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	0	0	19,893	0	183,976
54.00 05400	RADIOLOGY-DIAGNOSTIC	986	986	159,313	0	346,242
60.00 06000	LABORATORY	244	244	0	0	260,559
65.00 06500	RESPIRATORY THERAPY	485	485	555,486	0	755,930
66.00 06600	PHYSICAL THERAPY	10,335	10,335	0	0	963,143
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	505,530
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	564,580
74.00 07400	RENAL DIALYSIS	0	0	0	0	127,748
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)	55,755	55,755	5,778,140	-3,692,545	12,804,707
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	NONALLOWABLE CASE MANAGER	590	0	53,279	0	92,665
194.01 07951	IDLE SPACE	0	0	0	0	0
194.02 07952	REGIONAL OFFICE	0	0	0	0	0
194.03 07953	DISTRICT OFFICE	0	0	0	0	0
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05 07955	REG NURSG OFFICE	0	0	0	0	0
194.06 07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0
194.07 07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09 07958	VISITOR MEALS	0	0	0	0	0
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	347	0	419
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,082,826	1,272,149	1,215,116		3,692,545
203.00	Unit cost multiplier (Wkst. B, Part I)	36.965587	22.816770	0.208362		0.286293
204.00	Cost to be allocated (per Wkst. B, Part II)			17,217		255,590
205.00	Unit cost multiplier (Wkst. B, Part II)			0.002952		0.019817

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet B-1

Date/Time Prepared:
9/29/2014 11:51 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
		7.00	8.00	9.00	10.00	11.00	
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	46,663				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,780			8.00
9.00	00900	HOUSEKEEPING	892	0	45,771		9.00
10.00	01000	DIETARY	3,248	0	3,248	26,391	10.00
11.00	01100	CAFETERIA	0	0	0	11,631	71 11.00
13.00	01300	NURSING ADMINISTRATION	488	0	488	0	8 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,500	0	1,500	0	1 14.00
15.00	01500	PHARMACY	795	0	795	0	4 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	815	0	815	0	4 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	4 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,875	8,780	26,875	13,047	38 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	986	0	986	0	2 54.00
60.00	06000	LABORATORY	244	0	244	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	485	0	485	0	10 65.00
66.00	06600	PHYSICAL THERAPY	10,335	0	10,335	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
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	09500	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0 100.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	46,663	8,780	45,771	24,678	71 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0 194.00
194.01	07951	IDLE SPACE	0	0	0	0	0 194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0 194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0 194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0 194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0 194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0 194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0 194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0 194.08
194.09	07958	VISITOR MEALS	0	0	0	1,713	0 194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0 194.11
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,257,003	77,261	376,225	863,805	380,695 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.937895	8.799658	8.219724	32.731045	5,361.901408 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	407,951	1,190	67,045	239,415	105,515 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.742494	0.135535	1.464792	9.071843	1,486.126761 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

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	38					13.00
14.00	01400	0	644,966				14.00
15.00	01500	0	7,683	564,580			15.00
16.00	01600	0	82	0	46,734,560		16.00
17.00	01700	0	0	0	0	8,780	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	38	98,058	0	19,499,662	8,780	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	618,072	0	50.00
54.00	05400	0	946	0	1,235,205	0	54.00
60.00	06000	0	0	0	2,495,186	0	60.00
65.00	06500	0	32,121	0	7,537,233	0	65.00
66.00	06600	0	546	0	1,791,090	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	505,530	0	4,835,031	0	71.00
73.00	07300	0	0	564,580	8,183,343	0	73.00
74.00	07400	0	0	0	539,738	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		38	644,966	564,580	46,734,560	8,780	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		938,523	261,690	644,702	544,370	508,157	202.00
203.00		24,697.973684	0.405742	1.141914	0.011648	57.876651	203.00
204.00		61,164	109,753	72,980	71,244	14,283	204.00
205.00		1,609.578947	0.170169	0.129264	0.001524	1.626765	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet C
Part I
Date/Time Prepared:
9/29/2014 11:51 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE	Total Costs	
					Disallowance		
1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	9,976,654		9,976,654	2,897	9,979,551	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	243,846		243,846	0	243,846	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	505,531		505,531	0	505,531	54.00
60.00	06000 LABORATORY	372,798		372,798	0	372,798	60.00
65.00	06500 RESPIRATORY THERAPY	1,143,845	0	1,143,845	0	1,143,845	65.00
66.00	06600 PHYSICAL THERAPY	1,623,323	0	1,623,323	0	1,623,323	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	911,693		911,693	0	911,693	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,466,237		1,466,237	0	1,466,237	73.00
74.00	07400 RENAL DIALYSIS	170,608		170,608	0	170,608	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)	16,414,535	0	16,414,535	2,897	16,417,432	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	16,414,535	0	16,414,535	2,897	16,417,432	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet C
Part I
Date/Time Prepared:
9/29/2014 11:51 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,499,662		19,499,662		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	618,072	0	618,072	0.394527	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,235,205	0	1,235,205	0.409269	54.00
60.00	06000	LABORATORY	2,495,186	0	2,495,186	0.149407	60.00
65.00	06500	RESPIRATORY THERAPY	7,537,233	0	7,537,233	0.151759	65.00
66.00	06600	PHYSICAL THERAPY	1,791,090	0	1,791,090	0.906332	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	4,835,031	0	4,835,031	0.188560	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,183,343	0	8,183,343	0.179173	73.00
74.00	07400	RENAL DIALYSIS	539,738	0	539,738	0.316094	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)	46,734,560	0	46,734,560		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	46,734,560	0	46,734,560		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet C Part I Date/Time Prepared: 9/29/2014 11:51 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	0.394527		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.409269		54.00
60.00	06000 LABORATORY	0.149407		60.00
65.00	06500 RESPIRATORY THERAPY	0.151759		65.00
66.00	06600 PHYSICAL THERAPY	0.906332		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	0.188560		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.179173		73.00
74.00	07400 RENAL DIALYSIS	0.316094		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: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet C
Part I
Date/Time Prepared:
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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	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	9,976,654		9,976,654	2,897	9,979,551	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	243,846		243,846	0	243,846	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	505,531		505,531	0	505,531	54.00
60.00	06000 LABORATORY	372,798		372,798	0	372,798	60.00
65.00	06500 RESPIRATORY THERAPY	1,143,845	0	1,143,845	0	1,143,845	65.00
66.00	06600 PHYSICAL THERAPY	1,623,323	0	1,623,323	0	1,623,323	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	911,693		911,693	0	911,693	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,466,237		1,466,237	0	1,466,237	73.00
74.00	07400 RENAL DIALYSIS	170,608		170,608	0	170,608	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)	16,414,535	0	16,414,535	2,897	16,417,432	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	16,414,535	0	16,414,535	2,897	16,417,432	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet C
Part I
Date/Time Prepared:
9/29/2014 11:51 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,499,662		19,499,662		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	618,072	0	618,072	0.394527	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,235,205	0	1,235,205	0.409269	54.00
60.00	06000	LABORATORY	2,495,186	0	2,495,186	0.149407	60.00
65.00	06500	RESPIRATORY THERAPY	7,537,233	0	7,537,233	0.151759	65.00
66.00	06600	PHYSICAL THERAPY	1,791,090	0	1,791,090	0.906332	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	4,835,031	0	4,835,031	0.188560	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,183,343	0	8,183,343	0.179173	73.00
74.00	07400	RENAL DIALYSIS	539,738	0	539,738	0.316094	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)	46,734,560	0	46,734,560		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	46,734,560	0	46,734,560		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet C Part I Date/Time Prepared: 9/29/2014 11:51 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
100.00	10000 I&R SERVICES - NOT APPRVD. PRGM.			100.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 142013		Period: From 05/01/2013 To 04/30/2014		Worksheet D Part I Date/Time Prepared: 9/29/2014 11:51 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	2,286,994	0	2,286,994	8,780	260.48	30.00	
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
200.00	Total (Lines 30-199)	2,286,994		2,286,994	8,780		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	6,844	1,782,725					30.00
31.00	INTENSIVE CARE UNIT	0	0					31.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (Lines 30-199)	6,844	1,782,725					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet D Part II Date/Time Prepared: 9/29/2014 11:51 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	4,647	618,072	0.007519	527,825	3,969	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	81,355	1,235,205	0.065864	901,151	59,353	54.00
60.00	06000 LABORATORY	26,043	2,495,186	0.010437	2,023,809	21,122	60.00
65.00	06500 RESPIRATORY THERAPY	82,378	7,537,233	0.010929	5,432,140	59,368	65.00
66.00	06600 PHYSICAL THERAPY	745,253	1,791,090	0.416089	1,348,598	561,137	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	103,413	4,835,031	0.021388	3,611,336	77,239	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	96,639	8,183,343	0.011809	6,377,487	75,312	73.00
74.00	07400 RENAL DIALYSIS	3,355	539,738	0.006216	483,771	3,007	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (Lines 50-199)	1,143,083	27,234,898		20,706,117	860,507	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142013		Period: From 05/01/2013 To 04/30/2014		Worksheet D Part III Date/Time Prepared: 9/29/2014 11:51 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	8,780	0.00	6,844	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	8,780		6,844	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet D
Part IV
Date/Time Prepared:
9/29/2014 11:51 am

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet D
Part IV
Date/Time Prepared:
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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)	Hospital		
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	618,072	0.000000	0.000000	527,825	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,235,205	0.000000	0.000000	901,151	54.00
60.00	06000 LABORATORY	0	2,495,186	0.000000	0.000000	2,023,809	60.00
65.00	06500 RESPIRATORY THERAPY	0	7,537,233	0.000000	0.000000	5,432,140	65.00
66.00	06600 PHYSICAL THERAPY	0	1,791,090	0.000000	0.000000	1,348,598	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	4,835,031	0.000000	0.000000	3,611,336	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8,183,343	0.000000	0.000000	6,377,487	73.00
74.00	07400 RENAL DIALYSIS	0	539,738	0.000000	0.000000	483,771	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	27,234,898			20,706,117	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet D
Part IV
Date/Time Prepared:
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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	7,172	0	54.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,374	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	602	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	3,723	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	12,871	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet D Part V Date/Time Prepared: 9/29/2014 11:51 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	0.394527	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.409269	7,172	0	0	54.00
60.00	06000 LABORATORY	0.149407	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.151759	1,374	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.906332	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	0.188560	602	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.179173	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.316094	3,723	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.000000	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	98.00
200.00	Subtotal (see instructions)		12,871	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		12,871	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet D
Part V
Date/Time Prepared:
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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	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
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)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 9/29/2014 11:51 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)		8,780	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,780	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		8,780	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		6,844	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)		9,979,551	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)		9,979,551	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)		9,979,551	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)		1,136.62	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,779,027	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		7,779,027	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet D-1 Date/Time Prepared: 9/29/2014 11:51 am
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0 43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,902,623 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					12,681,650 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)					1,782,725 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					860,507 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,643,232 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,038,418 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142013		Period: From 05/01/2013 To 04/30/2014		Worksheet D-1 Date/Time Prepared: 9/29/2014 11:51 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	2,286,994	9,979,551	0.229168	0	0	90.00
91.00	Nursing School cost	0	9,979,551	0.000000	0	0	91.00
92.00	Allied health cost	0	9,979,551	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,979,551	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet D-1
		Title XIX		Date/Time Prepared: 9/29/2014 11:51 am
		Hospital		Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,780	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,780	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		8,780	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)		10	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)		9,976,654	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)		9,976,654	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)		9,976,654	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)		1,136.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		11,363	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)		11,363	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet D-1 Date/Time Prepared: 9/29/2014 11:51 am
Cost Center Description			Title XIX	Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	0	0	0.00	0	0
44.00					
45.00					
46.00					
47.00					
Cost Center Description					
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				7,842
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				19,205
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0
52.00	Total Program excludable cost (sum of lines 50 and 51)				0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142013		Period: From 05/01/2013 To 04/30/2014		Worksheet D-1 Date/Time Prepared: 9/29/2014 11:51 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	2,286,994	9,976,654	0.229235	0	0	90.00
91.00	Nursing School cost	0	9,976,654	0.000000	0	0	91.00
92.00	Allied health cost	0	9,976,654	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,976,654	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet D-2

Date/Time Prepared:
9/29/2014 11:51 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	8,780	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																																																																																																																														
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APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet D-2

Date/Time Prepared:
9/29/2014 11:51 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: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet D-2

Date/Time Prepared:
9/29/2014 11:51 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	6,844	10	0	0	2.00
3.00	INTENSIVE CARE UNIT	0	0	0	0	3.00
4.00	CORONARY CARE UNIT					4.00
5.00	BURN INTENSIVE CARE UNIT					5.00
6.00	SURGICAL INTENSIVE CARE UNIT					6.00
7.00	OTHER SPECIAL CARE (SPECIFY)					7.00
8.00	NURSERY					8.00
9.00	Subtotal (sum of lines 2 through 8)			0	0	9.00
10.00	SUBPROVIDER - IPF					10.00
11.00	SUBPROVIDER - IRF					11.00
12.00	SUBPROVIDER					12.00
13.00	SKILLED NURSING FACILITY	0	0	0	0	13.00
14.00	NURSING FACILITY					14.00
15.00	OTHER LONG TERM CARE					15.00
16.00	HOME HEALTH AGENCY					16.00
17.00	CMHC					17.00
18.00	AMBULATORY SURGICAL CENTER (D.P.)					18.00
19.00	HOSPICE					19.00
20.00	Subtotal (sum of lines 9 through 19)					20.00
Cost Center Description		Titles V and XIX Outpatient and Title XVIII Part B Charges		Titles V and XIX Outpatient and Title XVIII Part B Cost		
		Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX
		6.00	7.00	8.00	9.00	10.00
Hospital Outpatient Services:						
21.00	RURAL HEALTH CLINIC					21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER					22.00
23.00	CLINIC	0	0	0	0	23.00
24.00	EMERGENCY	0	0	0	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)					25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER					26.00
27.00	Subtotal (sum of lines 21 through 26)			0	0	27.00
28.00	Total (sum of lines 20 and 27)					28.00
Cost Center Description		Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents		
		6.00	7.00	11.00		
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: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet D-2

Date/Time Prepared:
9/29/2014 11:51 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: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet D-3 Date/Time Prepared: 9/29/2014 11:51 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		15,071,778		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.394527	527,825	208,241	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.409269	901,151	368,813	54.00
60.00	06000 LABORATORY	0.149407	2,023,809	302,371	60.00
65.00	06500 RESPIRATORY THERAPY	0.151759	5,432,140	824,376	65.00
66.00	06600 PHYSICAL THERAPY	0.906332	1,348,598	1,222,278	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	0.188560	3,611,336	680,954	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.179173	6,377,487	1,142,673	73.00
74.00	07400 RENAL DIALYSIS	0.316094	483,771	152,917	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)		20,706,117	4,902,623	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)		20,706,117		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet D-3 Date/Time Prepared: 9/29/2014 11:51 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		22,310	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.394527	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.409269	0	54.00
60.00	06000	LABORATORY	0.149407	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.151759	3,612	65.00
66.00	06600	PHYSICAL THERAPY	0.906332	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.188560	7,671	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.179173	32,640	73.00
74.00	07400	RENAL DIALYSIS	0.316094	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		43,923	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		43,923	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet E Part B Date/Time Prepared: 9/29/2014 11:51 am
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,435	2.00
3.00	PPS payments		1,778	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)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		1,778	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		386	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		1,392	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,392	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,392	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,392	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,392	40.00
40.01	Sequestration adjustment (see instructions)		28	40.01
41.00	Interim payments		1,365	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-1	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

Provider CCN: 142013 Period: From 05/01/2013 To 04/30/2014
 Worksheet E-1 Part I Date/Time Prepared: 9/29/2014 11:51 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		10,408,932		1,365	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		10,408,932		1,365	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		201,238		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1	6.02
7.00	Total Medicare program liability (see instructions)		10,610,170		1,364	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: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet E-3 Part IV Date/Time Prepared: 9/29/2014 11:51 am
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		10,017,602	1.00
2.00	Outlier Payments		1,190,589	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		11,208,191	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		0	5.00
6.00	Cost of teaching physicians		0	6.00
7.00	Subtotal (see instructions)		11,208,191	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8)		11,208,191	9.00
10.00	Deductibles		29,920	10.00
11.00	Subtotal (line 9 minus line 10)		11,178,271	11.00
12.00	Coinsurance		556,912	12.00
13.00	Subtotal (line 11 minus line 12)		10,621,359	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		315,915	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		205,345	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		315,525	16.00
17.00	Subtotal (sum of lines 13 and 15)		10,826,704	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)		10,826,704	22.00
22.01	Sequestration adjustment (see instructions)		216,534	22.01
23.00	Interim payments		10,408,932	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)		201,238	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part IV, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142013	Period: From 05/01/2013 To 04/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 9/29/2014 11:51 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	19,205		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)	19,205	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)	19,205	0	7.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	22,310		8.00	
9.00	Ancillary service charges	43,923	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)	66,233	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)	66,233	0	16.00	
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	47,028	0	17.00	
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00	
19.00	Interns and Residents (see instructions)	0	0	19.00	
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	19,205	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)	19,205	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)	19,205	0	31.00	
32.00	Deductibles	0	0	32.00	
33.00	Coinurance	0	0	33.00	
34.00	Allowable bad debts (see instructions)	0	0	34.00	
35.00	Utilization review	0		35.00	
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	19,205	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)	19,205	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)	19,205	0	40.00	
41.00	Interim payments	0	0	41.00	
42.00	Balance due provider/program (line 40 minus 41)	19,205	0	42.00	
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00	

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

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet G

Date/Time Prepared:
9/29/2014 11:51 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	2,936,313	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	3,336,439	0	0	0	4.00
5.00	Other receivable	2,435	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-399,136	0	0	0	6.00
7.00	Inventory	220,197	0	0	0	7.00
8.00	Prepaid expenses	150,669	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,246,917	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	197,980	0	0	0	17.00
18.00	Accumulated depreciation	-95,425	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	628,194	0	0	0	23.00
24.00	Accumulated depreciation	-334,248	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)	396,501	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	497,524	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	497,524	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	7,140,942	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	420,217	0	0	0	37.00
38.00	Salaries, wages, and fees payable	433,748	0	0	0	38.00
39.00	Payroll taxes payable	12,940	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	752,607	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,619,512	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	2,658,385	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,658,385	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,277,897	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	2,863,045				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	2,863,045	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	7,140,942	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet G-1

Date/Time Prepared:
9/29/2014 11:51 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		3,759,754		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-896,710			2.00
3.00	Total (sum of line 1 and line 2)		2,863,044		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)		2,863,045		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)		2,863,045		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments)		0			4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments)		0			12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet G-2
Parts I & II
Date/Time Prepared:
9/29/2014 11:51 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	19,499,662		19,499,662	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)	19,499,662		19,499,662	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)	19,499,662		19,499,662	17.00
18.00	Ancillary services	27,234,898	0	27,234,898	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)	46,734,560	0	46,734,560	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,422,782		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		16,422,782		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 142013

Period:
From 05/01/2013
To 04/30/2014

Worksheet G-3

Date/Time Prepared:
9/29/2014 11:51 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	46,734,560	1.00
2.00	Less contractual allowances and discounts on patients' accounts	32,069,878	2.00
3.00	Net patient revenues (line 1 minus line 2)	14,664,682	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,422,782	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,758,100	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	212	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	896	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	29,547	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	2,916	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	201	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	827,618	24.00
25.00	Total other income (sum of lines 6-24)	861,390	25.00
26.00	Total (line 5 plus line 25)	-896,710	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)	-896,710	29.00