This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 142008	Period: From 09/01/2012 To 08/31/2013	Worksheet S Parts I-III Date/Time Prepared: 1/29/2014 11:46 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/29/2014 Time: 11:46 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Kindred Hospital Chicago (142008) for the cost reporting period beginning 09/01/2012 and ending 08/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	70,481	5,446	0	9,469,964	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	70,481	5,446	0	9,469,964	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: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 1/29/2014 11:45 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 365 East North Avenue	PO Box:			1.00
2.00	City: Northlake	State: IL	Zip Code: 60164	County: Cook	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	Kindred Hospital Chicago	142008	16974	2	04/01/1991	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	09/01/2012	08/31/2013	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

		Urban/Rural S 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 1/29/2014 11:45 am

		Beginning:	Ending:	
		1.00	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	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)			39.00

		V	XVIII	XIX	
		1.00	2.00	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	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	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	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 1/29/2014 11:45 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
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
	Teaching Hospitals that Claim Residents in Non-Provider Settings					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	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 Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 1/29/2014 11:45 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 142008	Period: From 09/01/2012 To 08/31/2013	Worksheet S-2 Part I Date/Time Prepared: 1/29/2014 11:45 am

		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	109.00

		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	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	350,926	29,799	1,382,732	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	189003	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 142008	Period: From 09/01/2012 To 08/31/2013	Worksheet S-2 Part I Date/Time Prepared: 1/29/2014 11:45 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: KINDRED HEALTHCARE INC	Contractor's Name: WISCONSIN PHYSICIANS SERVICES	Contractor's Number: 05901	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	
	Multicampus		
165.00	Is this hospital part of a Multicampus 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	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

		Beginning	Ending	
		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: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 1/29/2014 11:45 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	03/31/2014	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	Y	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	12/31/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 1/29/2014 11:45 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
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 relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2013	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN	HOURIGAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	KINDRED HEALTHCARE INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5025967856	Daniel.Hourigan@kindred.com	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 1/29/2014 11:45 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	12/31/2013			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

VOLUNTARY CONTACT INFORMATION | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet S-2 Part V | Date/Time Prepared: 1/29/2014 11:45 am

		1.00	
	Cost Report Preparer Contact Information		
1.00	First Name	DAN	1.00
2.00	Last Name	HOURIGAN	2.00
3.00	Title	REIMBURSEMENT MANAGER	3.00
4.00	Employer	KINDRED HEALTHCARE INC	4.00
5.00	Phone Number	(502)596-7856	5.00
6.00	E-mail Address	Daniel.Hourigan@kindred.com	6.00
7.00	Department	REIMBURSEMENT	7.00
8.00	Mailing Address 1	680 SOUTH FOURTH AVENUE	8.00
9.00	Mailing Address 2	ATTN: SIXTH FLOOR REIMBURSEMENT	9.00
10.00	City	LOUISVILLE	10.00
11.00	State	KY	11.00
12.00	Zip	40202	12.00
	Officer or Administrator of Provider Contact Information		
13.00	First Name	ARTHUR L.	13.00
14.00	Last Name	ROTHGERBER	14.00
15.00	Title	SENIOR VICE PRESIDENT REIMBURSEMENT	15.00
16.00	Employer	KINDRED HEALTHCARE INC	16.00
17.00	Phone Number	(502)596-7995	17.00
18.00	E-mail Address	ART.ROTHGERBER@KINDRED.COM	18.00
19.00	Department	REIMBURSEMENT	19.00
20.00	Mailing Address 1	680 SOUTH FOURTH AVENUE	20.00
21.00	Mailing Address 2	ATTN: SIXTH FLOOR REIMBURSEMENT	21.00
22.00	City	LOUISVILLE	22.00
23.00	State	KY	23.00
24.00	Zip	40202	24.00

HFS Supplemental Information | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet S-2 Part IX | Date/Time Prepared: 1/29/2014 11:45 am

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 1/29/2014 11:45 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P 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	258	94,170	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)		258	94,170	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)		258	94,170	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)		258				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 1/29/2014 11:45 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)	17,051	32,971	59,839			1.00
2.00	HMO and other (see instructions)	972	4,273				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			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	17,051	32,971	59,839			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)	17,051	32,971	59,839	0.00	528.90	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	528.90	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	1,826					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 1/29/2014 11:45 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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	710	1,323	2,417	1.00
2.00	HMO and other (see instructions)			37			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	710	1,323	2,417	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet S-3 Part II Date/Time Prepared: 1/29/2014 11:45 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	30,364,426	-20,295	30,344,131	1,099,560.00	27.60	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	39,748	39,748	993.00	40.03	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		5,116,560	0	5,116,560	96,344.00	53.11	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		1,024,950	0	1,024,950	11,846.00	86.52	13.00
14.00	Home office salaries & wage-related costs		3,108,508	0	3,108,508	65,114.00	47.74	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,183,795	0	5,183,795			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		6,795	0	6,795			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	87,439	0	87,439	1,593.00	54.89	26.00
27.00	Administrative & General	5.00	3,411,140	-20,295	3,390,845	100,745.00	33.66	27.00
28.00	Administrative & General under contract (see inst.)		20,295	0	20,295	760.00	26.70	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	286,224	0	286,224	20,080.00	14.25	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	581,348	0	581,348	47,780.00	12.17	32.00
33.00	Housekeeping under contract (see instructions)		85,226	0	85,226	5,306.00	16.06	33.00
34.00	Dietary	10.00	733,607	0	733,607	45,215.00	16.22	34.00
35.00	Dietary under contract (see instructions)		98,850	0	98,850	5,439.00	18.17	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,618,148	0	1,618,148	37,958.00	42.63	38.00
39.00	Central Services and Supply	14.00	210,732	0	210,732	15,214.00	13.85	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,146,195	0	1,146,195	38,642.00	29.66	41.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet S-3 Part II Date/Time Prepared: 1/29/2014 11:45 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	
42.00	Social Service	17.00	1,116,519	-39,748	1,076,771	26,901.00	40.03	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet S-3 Part III Date/Time Prepared: 1/29/2014 11:45 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 III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		30,568,797	-20,295	30,548,502	1,111,065.00	27.49	1.00
2.00	Excluded area salaries (see instructions)		0	39,748	39,748	993.00	40.03	2.00
3.00	Subtotal salaries (line 1 minus line 2)		30,568,797	-60,043	30,508,754	1,110,072.00	27.48	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,250,018	0	9,250,018	173,304.00	53.37	4.00
5.00	Subtotal wage-related costs (see inst.)		5,183,795	0	5,183,795	0.00	16.99	5.00
6.00	Total (sum of lines 3 thru 5)		45,002,610	-60,043	44,942,567	1,283,376.00	35.02	6.00
7.00	Total overhead cost (see instructions)		9,395,723	-60,043	9,335,680	345,633.00	27.01	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet S-3 Part IV Date/Time Prepared: 1/29/2014 11:45 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	-2,899	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,427,986	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	141	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	24,644	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)	116,269	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	837,012	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,204,262	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	466,610	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	109,771	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,183,796	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: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet A | Date/Time Prepared: 1/29/2014 11:45 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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	CAP REL COSTS-BLDG & FIXT		9,037,780	9,037,780	1,174,894	10,212,674	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,681,613	1,681,613	537,528	2,219,141	2.00
3.00	00300	OTHER CAP REL COSTS		1,712,422	1,712,422	-1,712,422	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	87,439	5,456,104	5,543,543	0	5,543,543	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,411,140	18,473,646	21,884,786	0	21,884,786	5.00
7.00	00700	OPERATION OF PLANT	286,224	3,244,837	3,531,061	0	3,531,061	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	492,392	492,392	0	492,392	8.00
9.00	00900	HOUSEKEEPING	581,348	322,478	903,826	0	903,826	9.00
10.00	01000	DIETARY	733,607	1,128,160	1,861,767	0	1,861,767	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,618,148	52,348	1,670,496	0	1,670,496	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	210,732	157,557	368,289	0	368,289	14.00
15.00	01500	PHARMACY	0	1,952,426	1,952,426	0	1,952,426	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,146,195	385,519	1,531,714	0	1,531,714	16.00
17.00	01700	SOCIAL SERVICE	1,116,519	139,291	1,255,810	-44,700	1,211,110	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,749,840	2,691,475	16,441,315	2,658,861	19,100,176	30.00
31.00	03100	INTENSIVE CARE UNIT	2,544,241	114,620	2,658,861	-2,658,861	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	382,291	221,635	603,926	0	603,926	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	235,457	239,232	474,689	0	474,689	54.00
60.00	06000	LABORATORY	541,086	622,311	1,163,397	0	1,163,397	60.00
65.00	06500	RESPIRATORY THERAPY	3,664,055	104,253	3,768,308	0	3,768,308	65.00
66.00	06600	PHYSICAL THERAPY	0	2,711,608	2,711,608	0	2,711,608	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	3,378,985	3,378,985	0	3,378,985	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,455,617	3,455,617	0	3,455,617	73.00
74.00	07400	RENAL DIALYSIS	56,104	1,280,594	1,336,698	0	1,336,698	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,364,426	59,056,903	89,421,329	-44,700	89,376,629	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	44,700	44,700	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	788	788	0	788	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		TOTAL (SUM OF LINES 118-199)	30,364,426	59,057,691	89,422,117	0	89,422,117	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet A | Date/Time Prepared: 1/29/2014 11:45 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	-922,871	9,289,803		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-12,055	2,207,086		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,543,543		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,334,109	20,550,677		5.00
7.00	00700	OPERATION OF PLANT	450,482	3,981,543		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	492,392		8.00
9.00	00900	HOUSEKEEPING	108,096	1,011,922		9.00
10.00	01000	DIETARY	-118,573	1,743,194		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	145,925	1,816,421		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	368,289		14.00
15.00	01500	PHARMACY	-73	1,952,353		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,873	1,522,841		16.00
17.00	01700	SOCIAL SERVICE	0	1,211,110		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,129,973	17,970,203		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	-178,910	425,016		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	474,689		54.00
60.00	06000	LABORATORY	-14,541	1,148,856		60.00
65.00	06500	RESPIRATORY THERAPY	0	3,768,308		65.00
66.00	06600	PHYSICAL THERAPY	-188,123	2,523,485		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,378,985		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,455,617		73.00
74.00	07400	RENAL DIALYSIS	0	1,336,698		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)	-3,203,598	86,173,031		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	44,700		194.00
194.01	07951	IDLE SPACE	0	0		194.01
194.02	07952	REGIONAL OFFICE	0	788		194.02
194.03	07953	DISTRICT OFFICE	0	0		194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0		194.04
194.05	07955	REG NURSG OFFICE	0	0		194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0		194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0		194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0		194.08
194.09	07958	VISITOR MEALS	0	0		194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0		194.11
200.00		TOTAL (SUM OF LINES 118-199)	-3,203,598	86,218,519		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet Non-CMS W | Date/Time Prepared: 1/29/2014 11:45 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
44.00	SKILLED NURSING FACILITY	04400		44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	09500		95.00
98.00	OTHER REIMBURSABLE COST CENTERS	05950		98.00
100.00	I&R SERVICES - NOT APPRVD. PRGM.	10000		100.00
	SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	NONALLOWABLE CASE MANAGER	07950		194.00
194.01	IDLE SPACE	07951		194.01
194.02	REGIONAL OFFICE	07952		194.02
194.03	DISTRICT OFFICE	07953		194.03
194.04	NON MCR CERTIFIED UNIT	07954		194.04
194.05	REG NURSG OFFICE	07955		194.05
194.06	DATA CTR SUBLEASE (XODIAC)	07956		194.06
194.07	OTHER NONREIMBURSABLE - OPEN	07957		194.07
194.08	OTHER NONREIMBURSABLE - OPEN	07959		194.08
194.09	VISITOR MEALS	07958		194.09
194.10	OTHER NONREIMBURSABLE COST CENTERS	07962		194.10
194.11	NONREIMB NEW BUSINESS IMPLEMENTATION	07961		194.11
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet A-6 | Date/Time Prepared: 1/29/2014 11:45 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	39,748	4,952	1.00
	TOTALS		39,748	4,952	
	C - RECLASS ICU EXPENSE				
1.00	ADULTS & PEDIATRICS	30.00	2,544,241	114,620	1.00
	TOTALS		2,544,241	114,620	
	F - DEFAULT				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,295	1.00
	TOTALS		0	20,295	
500.00	Grand Total: Increases		2,583,989	139,867	500.00

RECLASSIFICATIONS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet A-6 | Date/Time Prepared: 1/29/2014 11:45 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS NON ALLOWABLE CASE MANAGER						
1.00	SOCIAL SERVICE	17.00	39,748	4,952	0		1.00
	TOTALS		39,748	4,952			
	C - RECLASS ICU EXPENSE						
1.00	INTENSIVE CARE UNIT	31.00	2,544,241	114,620	0		1.00
	TOTALS		2,544,241	114,620			
	F - DEFAULT						
1.00	ADMINISTRATIVE & GENERAL	5.00	20,295	0	0		1.00
	TOTALS		20,295	0			
500.00	Grand Total: Decreases		2,604,284	119,572			500.00

RECLASSIFICATIONS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 1/29/2014 11:45 am

	Increases			Decreases			
	Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	3.00	4.00	6.00	7.00	8.00	
	A - RECLASS NON ALLOWABLE CASE MANAGER						
1.00	NONALLOWABLE CASE MANAGER	194.00	39,748	SOCIAL SERVICE	17.00	39,748	1.00
	TOTALS		39,748	TOTALS		39,748	
	C - RECLASS ICU EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	2,544,241	INTENSIVE CARE UNIT	31.00	2,544,241	1.00
	TOTALS		2,544,241	TOTALS		2,544,241	
	F - DEFAULT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	ADMINISTRATIVE & GENERAL	5.00	20,295	1.00
	TOTALS		0	TOTALS		20,295	
500.00	Grand Total: Increases		2,583,989	Grand Total: Decreases		2,604,284	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet A-7 Part I | Date/Time Prepared: 1/29/2014 11:45 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	675,156	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	30,006,266	986,309	0	986,309	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	13,966,776	561,675	0	561,675	40,095	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	44,648,198	1,547,984	0	1,547,984	40,095	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	44,648,198	1,547,984	0	1,547,984	40,095	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	675,156	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	30,992,575	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	14,488,356	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	46,156,087	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	46,156,087	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet A-7 Part II | Date/Time Prepared: 1/29/2014 11:45 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	1,922,602	7,115,178	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	811,435	870,178	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,734,037	7,985,356	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	9,037,780	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,681,613	2.00
3.00	Total (sum of lines 1-2)	0	10,719,393	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet A-7 Part III | Date/Time Prepared: 1/29/2014 11:45 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	31,667,731	0	31,667,731	0.686101	74,574	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,488,356	0	14,488,356	0.313899	34,119	2.00
3.00	Total (sum of lines 1-2)	46,156,087	0	46,156,087	1.000000	108,693	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	1,100,320	0	1,174,894	1,018,752	7,115,178	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	503,409	0	537,528	799,380	870,178	2.00
3.00	Total (sum of lines 1-2)	1,603,729	0	1,712,422	1,818,132	7,985,356	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	55,553	1,100,320	0	9,289,803	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	34,119	503,409	0	2,207,086	2.00
3.00	Total (sum of lines 1-2)	0	89,672	1,603,729	0	11,496,889	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet A-8 | Date/Time Prepared: 1/29/2014 11:45 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-5,638	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	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-53,593	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-3,629	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,175,541			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	10,731			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-118,573	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	B	-73	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-10,832	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00			0		0.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-76,725	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet A-8 | Date/Time Prepared: 1/29/2014 11:45 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	
33.02			0		0.00	0	33.02
33.03			0		0.00	0	33.03
33.04			0		0.00	0	33.04
33.05	OCCUPATIONAL INCENTIVE INCOME	A	45,908	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PATIENT PERSONAL SERVICES EXPENSE	A	-90	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07			0		0.00	0	33.07
33.08	MEDICARE BAD DEBT - PART A	A	-1,784,360	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09			0		0.00	0	33.09
33.10	OTHER MEDICARE NON ALLOWABLE	A	-81,069	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	A	-302	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12			0		0.00	0	33.12
33.13	OTHER OPERATING - MARKETING	A	-37,867	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14			0		0.00	0	33.14
33.15	OTHER OPERATING - CASH OVER SHORT	A	-151	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16			0		0.00	0	33.16
33.17			0		0.00	0	33.17
33.18			0		0.00	0	33.18
33.19			0		0.00	0	33.19
33.20	OTHER OPERATING - TRADE SHOW BOOTH	A	-440	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21			0		0.00	0	33.21
33.22			0		0.00	0	33.22
33.23	CHARITABLE CONTRIBUTIONS	A	-34,240	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24			0		0.00	0	33.24
33.25	OTHER OPERATING - PENALTIES OTHER	A	-39,912	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26			0		0.00	0	33.26
33.27			0		0.00	0	33.27
33.28	AGGREGATE CAPITAL EROSION	A	-65,418	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	CABLE TV AND SATELLITE	A	-39,072	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30			0		0.00	0	33.30
33.31			0		0.00	0	33.31
33.32	RENT - OTHER	A	214,696	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33			0		0.00	0	33.33
33.34	MALPRACTICE TAIL LIABILITY	A	231,841	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	AGGREGATE CAP PYMT-NONALLOWABLE	A	225,339	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36			0		0.00	0	33.36
33.37	PHYSICIAN BILLING COLLECTION FEES	A	-9,501	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	A	-1,337,003	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
34.01	MEDICARE VS BOOK MOV EQUIP	A	-420,379	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.01
34.02	ASSET ADD-ON BLDG	A	57,407	CAP REL COSTS-BLDG & FIXT	1.00	9	34.02
34.03	ASSET ADD-ON MOV EQUIP	A	366,214	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.03
34.04			0		0.00	0	34.04
34.05			0		0.00	0	34.05
34.06	NON ALLOWABLE LOBBYING FEES	A	-18,457	ADMINISTRATIVE & GENERAL	5.00	0	34.06
34.07			0		0.00	0	34.07
34.08	BUSINESS INTERRUPTION INS PREMIUM	A	-19,021	CAP REL COSTS-BLDG & FIXT	1.00	12	34.08
34.09	REGIONAL OFFICE ALLOC - BLDG DEPREC	A	375,746	CAP REL COSTS-BLDG & FIXT	1.00	9	34.09
34.10	REGIONAL OFFICE ALLOC - EQUIP DEPREC	A	49,895	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.10
34.11	REGIONAL OFFICE ALLOC - PLANT OPER	A	454,111	OPERATION OF PLANT	7.00	0	34.11
34.12	REGIONAL OFFICE ALLOC - HOUSEKEEPING	A	108,096	HOUSEKEEPING	9.00	0	34.12
34.13			0		0.00	0	34.13
34.14	PHONE DEPREICATION - EQUIPMENT	A	-7,785	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.14
34.15			0		0.00	0	34.15
34.16			0		0.00	0	34.16
34.17			0		0.00	0	34.17
34.18			0		0.00	0	34.18

ADJUSTMENTS TO EXPENSES | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet A-8 | Date/Time Prepared: 1/29/2014 11:45 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.19			0		0.00	0	34.19
34.20			0		0.00	0	34.20
34.21			0		0.00	0	34.21
34.22	DISTRICT OFFICE SALES AND MARKETING	A	-3,912	ADMINISTRATIVE & GENERAL	5.00	0	34.22
34.23			0		0.00	0	34.23
34.24			0		0.00	0	34.24
35.00			0		0.00	0	35.00
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	PHYSICIAN FEE ADJUSTMENT	A	145,925	NURSING ADMINISTRATION	13.00	0	35.06
35.07			0		0.00	0	35.07
35.08			0		0.00	0	35.08
35.09	PHYSICIAN FEE ADJUSTMENT	A	3,938	MEDICAL RECORDS & LIBRARY	16.00	0	35.09
35.10			0		0.00	0	35.10
35.11	PHYSICIAN FEE ADJUSTMENT	A	-149,862	ADULTS & PEDIATRICS	30.00	0	35.11
35.12			0		0.00	0	35.12
35.13			0		0.00	0	35.13
35.14			0		0.00	0	35.14
35.15			0		0.00	0	35.15
35.16			0		0.00	0	35.16
35.17			0		0.00	0	35.17
35.18			0		0.00	0	35.18
35.19			0		0.00	0	35.19
35.20			0		0.00	0	35.20
35.21			0		0.00	0	35.21
35.22			0		0.00	0	35.22
35.23			0		0.00	0	35.23
35.24			0		0.00	0	35.24
35.25			0		0.00	0	35.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,203,598				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet A-8-1 | Date/Time Prepared: 1/29/2014 11:45 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	4,777,837	4,578,983	1.00
2.00	4.00	EMPLOYEE BENEFITS	Workers Comp Premium	798,960	798,960	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	1,487,138	1,487,138	3.00
4.00	0.00			0	0	4.00
4.01	66.00	PHYSICAL THERAPY	Therapy Services	2,521,759	2,709,882	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
5.00	0		0	9,585,694	9,574,963	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 142008	Period: From 09/01/2012 To 08/31/2013	Worksheet A-8-1 Date/Time Prepared: 1/29/2014 11:45 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	198,854	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	-188,123	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	10,731			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet A-8-2 | Date/Time Prepared: 1/29/2014 11:45 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	332,998	0	332,998	177,200	4,440	1.00
2.00	30.00	DR. B	428,448	428,448	0	177,200	0	2.00
3.00	30.00	DR. C	860	860	0	177,200	0	3.00
4.00	30.00	DR. D	15,956	0	15,956	177,200	101	4.00
5.00	30.00	DR. E	10,838	0	10,838	177,200	64	5.00
6.00	30.00	DR. F	10,413	0	10,413	177,200	61	6.00
7.00	30.00	DR. G	10,050	10,050	0	177,200	0	7.00
8.00	30.00	DR. H	431,641	0	431,641	177,200	5,755	8.00
9.00	30.00	DR. I	229,128	229,128	0	177,200	0	9.00
10.00	30.00	DR. J	107,558	107,558	0	177,200	0	10.00
11.00	30.00	DR. K	44,241	0	44,241	177,200	255	11.00
12.00	16.00	DR. L	3,938	0	3,938	177,200	23	12.00
13.00	30.00	DR. M	19,010	0	19,010	177,200	154	13.00
14.00	30.00	DR. N	15,914	0	15,914	177,200	99	14.00
15.00	30.00	DR. O	5,215	0	5,215	177,200	31	15.00
16.00	30.00	DR. P	11,595	0	11,595	177,200	65	16.00
17.00	60.00	DR. Q	34,555	0	34,555	215,700	193	17.00
18.00	30.00	DR. R	2,599	2,599	0	177,200	0	18.00
19.00	30.00	DR. S	7,275	0	7,275	177,200	49	19.00
20.00	30.00	DR. T	10,050	10,050	0	177,200	0	20.00
21.00	30.00	DR. U	59,194	59,194	0	177,200	0	21.00
22.00	30.00	DR. V	26,335	0	26,335	177,200	232	22.00
23.00	30.00	DR. W	55,026	0	55,026	177,200	324	23.00
24.00	50.00	DR. X	178,910	178,910	0	200,300	0	24.00
25.00	30.00	DR. Y	32,657	32,657	0	177,200	0	25.00
200.00			2,084,404	1,059,454	1,024,950		11,846	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	DR. A	378,254	18,913	0	0	0	1.00
2.00	30.00	DR. B	0	0	0	0	0	2.00
3.00	30.00	DR. C	0	0	0	0	0	3.00
4.00	30.00	DR. D	8,604	430	0	0	0	4.00
5.00	30.00	DR. E	5,452	273	0	0	0	5.00
6.00	30.00	DR. F	5,197	260	0	0	0	6.00
7.00	30.00	DR. G	0	0	0	0	0	7.00
8.00	30.00	DR. H	490,282	24,514	0	0	0	8.00
9.00	30.00	DR. I	0	0	0	0	0	9.00
10.00	30.00	DR. J	0	0	0	0	0	10.00
11.00	30.00	DR. K	21,724	1,086	0	0	0	11.00
12.00	16.00	DR. L	1,959	98	0	0	0	12.00
13.00	30.00	DR. M	13,120	656	0	0	0	13.00
14.00	30.00	DR. N	8,434	422	0	0	0	14.00
15.00	30.00	DR. O	2,641	132	0	0	0	15.00
16.00	30.00	DR. P	5,538	277	0	0	0	16.00
17.00	60.00	DR. Q	20,014	1,001	0	0	0	17.00
18.00	30.00	DR. R	0	0	0	0	0	18.00
19.00	30.00	DR. S	4,174	209	0	0	0	19.00
20.00	30.00	DR. T	0	0	0	0	0	20.00
21.00	30.00	DR. U	0	0	0	0	0	21.00
22.00	30.00	DR. V	19,765	988	0	0	0	22.00
23.00	30.00	DR. W	27,602	1,380	0	0	0	23.00
24.00	50.00	DR. X	0	0	0	0	0	24.00
25.00	30.00	DR. Y	0	0	0	0	0	25.00
200.00			1,012,760	50,639	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	DR. A	0	378,254	0	0		1.00
2.00	30.00	DR. B	0	0	0	428,448		2.00
3.00	30.00	DR. C	0	0	0	860		3.00
4.00	30.00	DR. D	0	8,604	7,352	7,352		4.00
5.00	30.00	DR. E	0	5,452	5,386	5,386		5.00
6.00	30.00	DR. F	0	5,197	5,216	5,216		6.00
7.00	30.00	DR. G	0	0	0	10,050		7.00
8.00	30.00	DR. H	0	490,282	0	0		8.00
9.00	30.00	DR. I	0	0	0	229,128		9.00
10.00	30.00	DR. J	0	0	0	107,558		10.00
11.00	30.00	DR. K	0	21,724	22,517	22,517		11.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet A-8-2 | Date/Time Prepared: 1/29/2014 11:45 am

	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		
12.00	16.00	DR. L	0	1,959	1,979	1,979		12.00
13.00	30.00	DR. M	0	13,120	5,890	5,890		13.00
14.00	30.00	DR. N	0	8,434	7,480	7,480		14.00
15.00	30.00	DR. O	0	2,641	2,574	2,574		15.00
16.00	30.00	DR. P	0	5,538	6,057	6,057		16.00
17.00	60.00	DR. Q	0	20,014	14,541	14,541		17.00
18.00	30.00	DR. R	0	0	0	2,599		18.00
19.00	30.00	DR. S	0	4,174	3,101	3,101		19.00
20.00	30.00	DR. T	0	0	0	10,050		20.00
21.00	30.00	DR. U	0	0	0	59,194		21.00
22.00	30.00	DR. V	0	19,765	6,570	6,570		22.00
23.00	30.00	DR. W	0	27,602	27,424	27,424		23.00
24.00	50.00	DR. X	0	0	0	178,910		24.00
25.00	30.00	DR. Y	0	0	0	32,657		25.00
200.00			0	1,012,760	116,087	1,175,541		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet B Part I Date/Time Prepared: 1/29/2014 11:45 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	9,289,803	9,289,803				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,207,086		2,207,086			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,543,543	267,160	64,070	5,874,773		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,550,677	889,032	213,207	658,380	22,311,296	5.00
7.00	00700	OPERATION OF PLANT	3,981,543	1,697,887	407,186	55,574	6,142,190	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	492,392	142,446	34,161	0	668,999	8.00
9.00	00900	HOUSEKEEPING	1,011,922	121,085	29,039	112,877	1,274,923	9.00
10.00	01000	DIETARY	1,743,194	491,423	117,853	142,440	2,494,910	10.00
11.00	01100	CAFETERIA	0	99,841	23,944	0	123,785	11.00
13.00	01300	NURSING ADMINISTRATION	1,816,421	68,648	16,463	314,186	2,215,718	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	368,289	448,408	107,537	40,917	965,151	14.00
15.00	01500	PHARMACY	1,952,353	173,815	41,684	0	2,167,852	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,522,841	108,620	26,049	222,550	1,880,060	16.00
17.00	01700	SOCIAL SERVICE	1,211,110	28,325	6,793	209,070	1,455,298	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,970,203	2,840,445	681,192	3,163,737	24,655,577	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	425,016	342,422	82,119	74,227	923,784	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,689	125,533	30,105	45,717	676,044	54.00
60.00	06000	LABORATORY	1,148,856	132,966	31,888	105,059	1,418,769	60.00
65.00	06500	RESPIRATORY THERAPY	3,768,308	138,759	33,277	711,428	4,651,772	65.00
66.00	06600	PHYSICAL THERAPY	2,523,485	251,827	60,393	0	2,835,705	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	3,378,985	0	0	0	3,378,985	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,455,617	0	0	0	3,455,617	73.00
74.00	07400	RENAL DIALYSIS	1,336,698	59,636	14,302	10,893	1,421,529	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	86,173,031	8,428,278	2,021,262	5,867,055	85,117,964	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	35,407	8,491	0	43,898	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	44,700	0	0	7,718	52,418	194.00
194.01	07951	IDLE SPACE	0	86,673	0	0	86,673	194.01
194.02	07952	REGIONAL OFFICE	788	349,210	83,747	0	433,745	194.02
194.03	07953	DISTRICT OFFICE	0	390,235	93,586	0	483,821	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	86,218,519	9,289,803	2,207,086	5,874,773	86,218,519	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet B Part I | Date/Time Prepared: 1/29/2014 11:45 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	22,311,296					5.00
7.00	00700	OPERATION OF PLANT	2,178,598	8,320,788				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	237,290	186,684	1,092,973			8.00
9.00	00900	HOUSEKEEPING	452,208	158,689	0	1,885,820		9.00
10.00	01000	DIETARY	884,930	644,037	0	152,285	4,176,162	10.00
11.00	01100	CAFETERIA	43,906	130,848	0	30,939	2,084,864	11.00
13.00	01300	NURSING ADMINISTRATION	785,902	89,967	0	21,273	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	342,333	587,664	0	138,956	0	14.00
15.00	01500	PHARMACY	768,924	227,794	0	53,863	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	666,846	142,352	0	33,660	0	16.00
17.00	01700	SOCIAL SERVICE	516,185	37,122	0	8,778	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,745,168	3,722,561	1,092,973	880,214	2,029,558	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	327,661	448,763	0	106,112	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	239,789	164,518	0	38,901	0	54.00
60.00	06000	LABORATORY	503,229	174,259	0	41,204	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,649,956	181,852	0	43,000	0	65.00
66.00	06600	PHYSICAL THERAPY	1,005,808	330,034	0	78,038	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,198,506	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,225,687	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	504,208	78,156	0	18,480	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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)	22,277,134	7,305,300	1,092,973	1,645,703	4,114,422	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,570	46,403	0	10,972	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	18,592	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	457,660	0	108,216	0	194.02
194.03	07953	DISTRICT OFFICE	0	511,425	0	120,929	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	61,740	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	22,311,296	8,320,788	1,092,973	1,885,820	4,176,162	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet B Part I Date/Time Prepared: 1/29/2014 11:45 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	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	2,414,342					11.00
13.00	01300	NURSING ADMINISTRATION	102,254	3,215,114				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39,766	0	2,073,870			14.00
15.00	01500	PHARMACY	0	0	10,333	3,228,766		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	107,935	0	1,348	0	2,832,201	16.00
17.00	01700	SOCIAL SERVICE	73,850	0	35	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,630,393	3,163,240	52,320	148,659	1,125,830	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	28,404	51,874	319	0	21,783	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,042	0	1,790	11,742	59,403	54.00
60.00	06000	LABORATORY	73,850	0	2,741	0	214,605	60.00
65.00	06500	RESPIRATORY THERAPY	335,167	0	1,837	0	481,240	65.00
66.00	06600	PHYSICAL THERAPY	0	0	185	0	91,170	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	2,002,778	0	213,194	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,068,365	580,169	73.00
74.00	07400	RENAL DIALYSIS	5,681	0	184	0	44,807	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,414,342	3,215,114	2,073,870	3,228,766	2,832,201	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,414,342	3,215,114	2,073,870	3,228,766	2,832,201	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet B Part I | Date/Time Prepared: 1/29/2014 11:45 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	2,091,268					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,091,268	49,337,761	0	49,337,761		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,908,700	0	1,908,700		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,209,229	0	1,209,229		54.00
60.00	06000	LABORATORY	0	2,428,657	0	2,428,657		60.00
65.00	06500	RESPIRATORY THERAPY	0	7,344,824	0	7,344,824		65.00
66.00	06600	PHYSICAL THERAPY	0	4,340,940	0	4,340,940		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	6,793,463	0	6,793,463		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,329,838	0	8,329,838		73.00
74.00	07400	RENAL DIALYSIS	0	2,073,045	0	2,073,045		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)	2,091,268	83,766,457	0	83,766,457		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	116,843	0	116,843		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	71,010	0	71,010		194.00
194.01	07951	IDLE SPACE	0	86,673	0	86,673		194.01
194.02	07952	REGIONAL OFFICE	0	999,621	0	999,621		194.02
194.03	07953	DISTRICT OFFICE	0	1,116,175	0	1,116,175		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	61,740	0	61,740		194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0		194.11
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	2,091,268	86,218,519	0	86,218,519		202.00

COST ALLOCATION STATISTICS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet Non-CMS W | Date/Time Prepared: 1/29/2014 11:45 am

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET #1	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	SQUARE FEET #2	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	7	SQUARE FEET #3	7.00
8.00	LAUNDRY & LINEN SERVICE	P	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	9	SQUARE FEET #4	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	CAFETERIA FTES	11.00
13.00	NURSING ADMINISTRATION	13	NURSING FTES	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS REVENUE	16.00
17.00	SOCIAL SERVICE	P	PATIENT DAYS	17.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet B Part II | Date/Time Prepared: 1/29/2014 11:45 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		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	267,160	64,070	331,230	331,230	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	533,379	889,032	213,207	1,635,618	37,120	5.00
7.00	00700	OPERATION OF PLANT	0	1,697,887	407,186	2,105,073	3,133	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	142,446	34,161	176,607	0	8.00
9.00	00900	HOUSEKEEPING	0	121,085	29,039	150,124	6,364	9.00
10.00	01000	DIETARY	0	491,423	117,853	609,276	8,031	10.00
11.00	01100	CAFETERIA	0	99,841	23,944	123,785	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	68,648	16,463	85,111	17,714	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	448,408	107,537	555,945	2,307	14.00
15.00	01500	PHARMACY	0	173,815	41,684	215,499	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	108,620	26,049	134,669	12,547	16.00
17.00	01700	SOCIAL SERVICE	0	28,325	6,793	35,118	11,787	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,840,445	681,192	3,521,637	178,382	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	342,422	82,119	424,541	4,185	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	125,533	30,105	155,638	2,578	54.00
60.00	06000	LABORATORY	0	132,966	31,888	164,854	5,923	60.00
65.00	06500	RESPIRATORY THERAPY	0	138,759	33,277	172,036	40,110	65.00
66.00	06600	PHYSICAL THERAPY	0	251,827	60,393	312,220	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	59,636	14,302	73,938	614	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	533,379	8,428,278	2,021,262	10,982,919	330,795	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	35,407	8,491	43,898	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	435	194.00
194.01	07951	IDLE SPACE	0	86,673	0	86,673	0	194.01
194.02	07952	REGIONAL OFFICE	0	349,210	83,747	432,957	0	194.02
194.03	07953	DISTRICT OFFICE	0	390,235	93,586	483,821	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	533,379	9,289,803	2,207,086	12,030,268	331,230	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet B Part II | Date/Time Prepared: 1/29/2014 11:45 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,672,738					5.00
7.00	00700	OPERATION OF PLANT	163,333	2,271,539				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,790	50,964	245,361			8.00
9.00	00900	HOUSEKEEPING	33,903	43,321	0	233,712		9.00
10.00	01000	DIETARY	66,345	175,819	0	18,873	878,344	10.00
11.00	01100	CAFETERIA	3,292	35,721	0	3,834	438,496	11.00
13.00	01300	NURSING ADMINISTRATION	58,920	24,561	0	2,636	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,665	160,430	0	17,221	0	14.00
15.00	01500	PHARMACY	57,648	62,187	0	6,675	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	49,995	38,862	0	4,172	0	16.00
17.00	01700	SOCIAL SERVICE	38,699	10,134	0	1,088	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	655,663	1,016,242	245,361	109,087	426,863	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	24,565	122,510	0	13,151	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,977	44,913	0	4,821	0	54.00
60.00	06000	LABORATORY	37,728	47,572	0	5,106	0	60.00
65.00	06500	RESPIRATORY THERAPY	123,700	49,645	0	5,329	0	65.00
66.00	06600	PHYSICAL THERAPY	75,407	90,098	0	9,671	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	89,854	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91,892	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	37,801	21,336	0	2,290	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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)	1,670,177	1,994,315	245,361	203,954	865,359	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,167	12,668	0	1,360	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	1,394	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	124,939	0	13,411	0	194.02
194.03	07953	DISTRICT OFFICE	0	139,617	0	14,987	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	12,985	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,672,738	2,271,539	245,361	233,712	878,344	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet B Part II | Date/Time Prepared: 1/29/2014 11:45 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	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	605,128					11.00
13.00	01300	NURSING ADMINISTRATION	25,629	214,571				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,967	0	771,535			14.00
15.00	01500	PHARMACY	0	0	3,844	345,853		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,053	0	501	0	267,799	16.00
17.00	01700	SOCIAL SERVICE	18,510	0	13	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	408,639	211,109	19,464	15,924	106,504	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	7,119	3,462	119	0	2,059	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,271	0	666	1,258	5,615	54.00
60.00	06000	LABORATORY	18,510	0	1,020	0	20,286	60.00
65.00	06500	RESPIRATORY THERAPY	84,006	0	683	0	45,489	65.00
66.00	06600	PHYSICAL THERAPY	0	0	69	0	8,618	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	745,088	0	20,152	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	328,671	54,841	73.00
74.00	07400	RENAL DIALYSIS	1,424	0	68	0	4,235	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	605,128	214,571	771,535	345,853	267,799	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	605,128	214,571	771,535	345,853	267,799	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet B Part II Date/Time Prepared: 1/29/2014 11:45 am

		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	115,349					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	115,349	7,030,224	0	7,030,224		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	601,711	0	601,711		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	237,737	0	237,737		54.00
60.00	06000	LABORATORY	0	300,999	0	300,999		60.00
65.00	06500	RESPIRATORY THERAPY	0	520,998	0	520,998		65.00
66.00	06600	PHYSICAL THERAPY	0	496,083	0	496,083		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	855,094	0	855,094		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	475,404	0	475,404		73.00
74.00	07400	RENAL DIALYSIS	0	141,706	0	141,706		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)	115,349	10,659,956	0	10,659,956		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	59,093	0	59,093		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	1,829	0	1,829		194.00
194.01	07951	IDLE SPACE	0	86,673	0	86,673		194.01
194.02	07952	REGIONAL OFFICE	0	571,307	0	571,307		194.02
194.03	07953	DISTRICT OFFICE	0	638,425	0	638,425		194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0		194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0		194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0		194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0		194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0		194.08
194.09	07958	VISITOR MEALS	0	12,985	0	12,985		194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0		194.11
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	115,349	12,030,268	0	12,030,268		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet B-1 | Date/Time Prepared: 1/29/2014 11:45 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET #1)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET #2)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	158,736					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		157,255				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,565	4,565	30,256,692			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,191	15,191	3,390,845	-22,311,296	62,902,984	5.00
7.00	00700	OPERATION OF PLANT	29,012	29,012	286,224	0	6,142,190	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,434	2,434	0	0	668,999	8.00
9.00	00900	HOUSEKEEPING	2,069	2,069	581,348	0	1,274,923	9.00
10.00	01000	DIETARY	8,397	8,397	733,607	0	2,494,910	10.00
11.00	01100	CAFETERIA	1,706	1,706	0	0	123,785	11.00
13.00	01300	NURSING ADMINISTRATION	1,173	1,173	1,618,148	0	2,215,718	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,662	7,662	210,732	0	965,151	14.00
15.00	01500	PHARMACY	2,970	2,970	0	0	2,167,852	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,856	1,856	1,146,195	0	1,880,060	16.00
17.00	01700	SOCIAL SERVICE	484	484	1,076,771	0	1,455,298	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,535	48,535	16,294,081	0	24,655,577	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	5,851	5,851	382,291	0	923,784	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,145	2,145	235,457	0	676,044	54.00
60.00	06000	LABORATORY	2,272	2,272	541,086	0	1,418,769	60.00
65.00	06500	RESPIRATORY THERAPY	2,371	2,371	3,664,055	0	4,651,772	65.00
66.00	06600	PHYSICAL THERAPY	4,303	4,303	0	0	2,835,705	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	3,378,985	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,455,617	73.00
74.00	07400	RENAL DIALYSIS	1,019	1,019	56,104	0	1,421,529	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	144,015	144,015	30,216,944	-22,311,296	62,806,668	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	605	605	0	0	43,898	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	39,748	0	52,418	194.00
194.01	07951	IDLE SPACE	1,481	0	0	-86,673	0	194.01
194.02	07952	REGIONAL OFFICE	5,967	5,967	0	-433,745	0	194.02
194.03	07953	DISTRICT OFFICE	6,668	6,668	0	-483,821	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	9,289,803	2,207,086	5,874,773		22,311,296	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	58.523605	14.035077	0.194164		0.354694	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			331,230		1,672,738	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.010947		0.026592	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet B-1 | Date/Time Prepared: 1/29/2014 11:45 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	108,487					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,434	59,839				8.00
9.00	00900	HOUSEKEEPING	2,069	0	103,984			9.00
10.00	01000	DIETARY	8,397	0	8,397	183,713		10.00
11.00	01100	CAFETERIA	1,706	0	1,706	91,715	425	11.00
13.00	01300	NURSING ADMINISTRATION	1,173	0	1,173	0	18	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,662	0	7,662	0	7	14.00
15.00	01500	PHARMACY	2,970	0	2,970	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,856	0	1,856	0	19	16.00
17.00	01700	SOCIAL SERVICE	484	0	484	0	13	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,535	59,839	48,535	89,282	287	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	5,851	0	5,851	0	5	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,145	0	2,145	0	3	54.00
60.00	06000	LABORATORY	2,272	0	2,272	0	13	60.00
65.00	06500	RESPIRATORY THERAPY	2,371	0	2,371	0	59	65.00
66.00	06600	PHYSICAL THERAPY	4,303	0	4,303	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	1,019	0	1,019	0	1	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	95,247	59,839	90,744	180,997	425	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	605	0	605	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	5,967	0	5,967	0	0	194.02
194.03	07953	DISTRICT OFFICE	6,668	0	6,668	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	2,716	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)	8,320,788	1,092,973	1,885,820	4,176,162	2,414,342	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	76.698480	18.265228	18.135675	22.731990	5,680.804706	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,271,539	245,361	233,712	878,344	605,128	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	20.938352	4.100353	2.247577	4.781066	1,423.830588	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet B-1 | Date/Time Prepared: 1/29/2014 11:45 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		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	2,913					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,498,928				14.00
15.00	01500	PHARMACY	0	17,434	3,636,262			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,274	0	316,463,473		16.00
17.00	01700	SOCIAL SERVICE	0	59	0	0	59,839	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,866	88,271	167,421	125,807,525	59,839	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	47	539	0	2,433,842	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,020	13,224	6,637,176	0	54.00
60.00	06000	LABORATORY	0	4,625	0	23,978,243	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,099	0	53,769,821	0	65.00
66.00	06600	PHYSICAL THERAPY	0	312	0	10,186,565	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	3,378,985	0	23,820,571	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,455,617	64,823,343	0	73.00
74.00	07400	RENAL DIALYSIS	0	310	0	5,006,387	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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)	2,913	3,498,928	3,636,262	316,463,473	59,839	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,215,114	2,073,870	3,228,766	2,832,201	2,091,268	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,103.712324	0.592716	0.887935	0.008950	34.948244	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	214,571	771,535	345,853	267,799	115,349	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	73.659801	0.220506	0.095112	0.000846	1.927656	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet C Part I Date/Time Prepared: 1/29/2014 11:45 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,337,761		49,337,761	99,567	49,437,328	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,908,700		1,908,700	0	1,908,700	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,209,229		1,209,229	0	1,209,229	54.00
60.00	06000	LABORATORY	2,428,657		2,428,657	14,541	2,443,198	60.00
65.00	06500	RESPIRATORY THERAPY	7,344,824	0	7,344,824	0	7,344,824	65.00
66.00	06600	PHYSICAL THERAPY	4,340,940	0	4,340,940	0	4,340,940	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	6,793,463		6,793,463	0	6,793,463	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,329,838		8,329,838	0	8,329,838	73.00
74.00	07400	RENAL DIALYSIS	2,073,045		2,073,045	0	2,073,045	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	100.00
200.00		Subtotal (see instructions)	83,766,457	0	83,766,457	114,108	83,880,565	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	83,766,457	0	83,766,457	114,108	83,880,565	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet C Part I Date/Time Prepared: 1/29/2014 11:45 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	125,807,525		125,807,525			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,433,842	0	2,433,842	0.784233	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,637,176	0	6,637,176	0.182190	0.000000	54.00
60.00	06000	LABORATORY	23,978,243	0	23,978,243	0.101286	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	53,769,821	0	53,769,821	0.136598	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	10,186,565	0	10,186,565	0.426144	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,820,571	0	23,820,571	0.285193	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,823,343	0	64,823,343	0.128501	0.000000	73.00
74.00	07400	RENAL DIALYSIS	5,006,387	0	5,006,387	0.414080	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0			100.00
200.00		Subtotal (see instructions)	316,463,473	0	316,463,473			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	316,463,473	0	316,463,473			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet C Part I Date/Time Prepared: 1/29/2014 11:45 am

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		Cost Center Description	PPS Inpatient Ratio	
			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	0.784233	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182190	54.00
60.00	06000	LABORATORY	0.101892	60.00
65.00	06500	RESPIRATORY THERAPY	0.136598	65.00
66.00	06600	PHYSICAL THERAPY	0.426144	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	0.285193	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.128501	73.00
74.00	07400	RENAL DIALYSIS	0.414080	74.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.		100.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet C Part I Date/Time Prepared: 1/29/2014 11:45 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,337,761		49,337,761	99,567	49,437,328	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,908,700		1,908,700	0	1,908,700	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,209,229		1,209,229	0	1,209,229	54.00
60.00	06000	LABORATORY	2,428,657		2,428,657	14,541	2,443,198	60.00
65.00	06500	RESPIRATORY THERAPY	7,344,824	0	7,344,824	0	7,344,824	65.00
66.00	06600	PHYSICAL THERAPY	4,340,940	0	4,340,940	0	4,340,940	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	6,793,463		6,793,463	0	6,793,463	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,329,838		8,329,838	0	8,329,838	73.00
74.00	07400	RENAL DIALYSIS	2,073,045		2,073,045	0	2,073,045	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	100.00
200.00		Subtotal (see instructions)	83,766,457	0	83,766,457	114,108	83,880,565	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	83,766,457	0	83,766,457	114,108	83,880,565	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet C Part I Date/Time Prepared: 1/29/2014 11:45 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	125,807,525		125,807,525			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,433,842	0	2,433,842	0.784233	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,637,176	0	6,637,176	0.182190	0.000000	54.00
60.00	06000	LABORATORY	23,978,243	0	23,978,243	0.101286	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	53,769,821	0	53,769,821	0.136598	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	10,186,565	0	10,186,565	0.426144	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,820,571	0	23,820,571	0.285193	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,823,343	0	64,823,343	0.128501	0.000000	73.00
74.00	07400	RENAL DIALYSIS	5,006,387	0	5,006,387	0.414080	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0			100.00
200.00		Subtotal (see instructions)	316,463,473	0	316,463,473			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	316,463,473	0	316,463,473			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet C Part I Date/Time Prepared: 1/29/2014 11:45 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			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: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D Part I Date/Time Prepared: 1/29/2014 11:45 am

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	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,030,224	0	7,030,224	59,839	117.49	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	7,030,224		7,030,224	59,839		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	17,051	2,003,322	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)	17,051	2,003,322	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D Part II Date/Time Prepared: 1/29/2014 11:45 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	601,711	2,433,842	0.247227	925,028	228,692	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	237,737	6,637,176	0.035819	1,896,161	67,919	54.00
60.00	06000	LABORATORY	300,999	23,978,243	0.012553	7,735,022	97,098	60.00
65.00	06500	RESPIRATORY THERAPY	520,998	53,769,821	0.009689	15,386,086	149,076	65.00
66.00	06600	PHYSICAL THERAPY	496,083	10,186,565	0.048700	3,095,401	150,746	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	855,094	23,820,571	0.035897	7,241,024	259,931	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	475,404	64,823,343	0.007334	19,446,131	142,618	73.00
74.00	07400	RENAL DIALYSIS	141,706	5,006,387	0.028305	2,093,219	59,249	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						95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50-199)	3,629,732	190,655,948		57,818,072	1,155,329	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D Part III Date/Time Prepared: 1/29/2014 11:45 am

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		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	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	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)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,839	0.00	17,051	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	0	44.00
200.00		Total (lines 30-199)	59,839		17,051	0	0	200.00

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
			12.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
200.00		Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D Part IV Date/Time Prepared: 1/29/2014 11:45 am

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		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,433,842	0.000000	0.000000	925,028	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,637,176	0.000000	0.000000	1,896,161	54.00
60.00	06000	LABORATORY	0	23,978,243	0.000000	0.000000	7,735,022	60.00
65.00	06500	RESPIRATORY THERAPY	0	53,769,821	0.000000	0.000000	15,386,086	65.00
66.00	06600	PHYSICAL THERAPY	0	10,186,565	0.000000	0.000000	3,095,401	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	23,820,571	0.000000	0.000000	7,241,024	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	64,823,343	0.000000	0.000000	19,446,131	73.00
74.00	07400	RENAL DIALYSIS	0	5,006,387	0.000000	0.000000	2,093,219	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						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	190,655,948			57,818,072	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D Part IV Date/Time Prepared: 1/29/2014 11:45 am

Title XVIII | Hospital | PPS

		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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D Part IV | Date/Time Prepared: 1/29/2014 11:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		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				95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D Part V Date/Time Prepared: 1/29/2014 11:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.784233	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182190	0	1,016,778	0	0	54.00
60.00	06000	LABORATORY	0.101286	0	49,121	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.136598	0	599,282	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.426144	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.285193	0	82,645	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.128501	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.414080	0	1,169,114	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	2,916,940	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)		0	2,916,940	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D Part V Date/Time Prepared: 1/29/2014 11:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: 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	185,247	0		54.00
60.00	06000	LABORATORY	4,975	0		60.00
65.00	06500	RESPIRATORY THERAPY	81,861	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	23,570	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	484,107	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)	779,760	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	779,760	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D-1 | Date/Time Prepared: 1/29/2014 11:45 am

Title XVIII | Hospital | PPS

	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)	59,839	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	59,839	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	59,839	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)	17,051	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	49,437,328	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	49,437,328	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	49,437,328	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)	826.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	14,087,025	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)	14,087,025	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D-1 | Date/Time Prepared: 1/29/2014 11:45 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)	10,710,528	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	24,797,553	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)	2,003,322	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,155,329	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,158,651	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	21,638,902	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D-1 | Date/Time Prepared: 1/29/2014 11:45 am

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	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	7,030,224	49,437,328	0.142205	0	0	90.00
91.00	Nursing School cost	0	49,437,328	0.000000	0	0	91.00
92.00	Allied health cost	0	49,437,328	0.000000	0	0	92.00
93.00	All other Medical Education	0	49,437,328	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 142008	Period: From 09/01/2012 To 08/31/2013	Worksheet D-1 Date/Time Prepared: 1/29/2014 11:45 am
	Title XIX	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)	59,839	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	59,839	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	59,839	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)	32,971	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	49,337,761	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	49,337,761	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	49,337,761	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)	824.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	27,184,919	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)	27,184,919	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D-1 | Date/Time Prepared: 1/29/2014 11:45 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	16,867,984	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	44,052,903	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D-1 | Date/Time Prepared: 1/29/2014 11:45 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D-2 | Date/Time Prepared: 1/29/2014 11:45 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						
1.00	Total cost of services rendered	0.00	0				1.00
	Hospital Inpatient Routine Services:						
2.00	ADULTS & PEDIATRICS	0.00	0	59,839	0.00	0	2.00
3.00	INTENSIVE CARE UNIT	0.00	0	0	0.00	0	3.00
4.00	CORONARY CARE UNIT						4.00
5.00	BURN INTENSIVE CARE UNIT						5.00
6.00	SURGICAL INTENSIVE CARE UNIT						6.00
7.00	OTHER SPECIAL CARE (SPECIFY)						7.00
8.00	NURSERY						8.00
9.00	Subtotal (sum of lines 2 through 8)	0.00	0				9.00
10.00	SUBPROVIDER - IPF						10.00
11.00	SUBPROVIDER - IRF						11.00
12.00	SUBPROVIDER						12.00
13.00	SKILLED NURSING FACILITY	0.00	0	0	0.00	0	13.00
14.00	NURSING FACILITY						14.00
15.00	OTHER LONG TERM CARE						15.00
16.00	HOME HEALTH AGENCY						16.00
17.00	CMHC						17.00
18.00	AMBULATORY SURGICAL CENTER (D.P.)						18.00
19.00	HOSPICE						19.00
20.00	Subtotal (sum of lines 9 through 19)	0.00	0				20.00

	Cost Center Description			Total Charges (from Worksheet C. Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V	
		1.00	2.00	3.00	4.00	5.00	
	Hospital Outpatient Services:						
21.00	RURAL HEALTH CLINIC						21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER						22.00
23.00	CLINIC	0.00	0	0	0.000000	0	23.00
24.00	EMERGENCY	0.00	0	0	0.000000	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)						25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER						26.00
27.00	Subtotal (sum of lines 21 through 26)	0.00	0				27.00
28.00	Total (sum of lines 20 and 27)	0.00	0				28.00

	Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)						
	Hospital Inpatient Routine Services:						
29.00	ADULTS & PEDIATRICS	0	0	0	59,839	0.00	29.00
30.00	Swing Bed - SNF		0	0	0	0.00	30.00
31.00	Swing Bed - NF		0				31.00
32.00	INTENSIVE CARE UNIT	0		0	0	0.00	32.00
33.00	CORONARY CARE UNIT						33.00
34.00	BURN INTENSIVE CARE UNIT						34.00
35.00	SURGICAL INTENSIVE CARE UNIT						35.00
36.00	OTHER SPECIAL CARE (SPECIFY)						36.00
37.00	Subtotal (sum of lines 28, and 29 through 36)	0		0			37.00
38.00	SUBPROVIDER - IPF						38.00
39.00	SUBPROVIDER - IRF						39.00
40.00	SUBPROVIDER						40.00
41.00	SKILLED NURSING FACILITY	0		0	0	0.00	41.00
42.00	Total (sum of lines 37 through 41)	0		0			42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D-2 | Date/Time Prepared: 1/29/2014 11:45 am

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

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D-2 | Date/Time Prepared: 1/29/2014 11:45 am

	Cost Center Description	Health Care Program Inpatient Days: Title XVIII, Part B Only less Part A Coverage but no Part B Coverage	Health Care Program Inpatient Days: Title XIX	Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
		6.00	7.00	8.00	9.00	10.00	
	PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00	Total cost of services rendered						1.00
	Hospital Inpatient Routine Services:						
2.00	ADULTS & PEDIATRICS	17,051	32,971	0	0	0	2.00
3.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	CORONARY CARE UNIT						4.00
5.00	BURN INTENSIVE CARE UNIT						5.00
6.00	SURGICAL INTENSIVE CARE UNIT						6.00
7.00	OTHER SPECIAL CARE (SPECIFY)						7.00
8.00	NURSERY						8.00
9.00	Subtotal (sum of lines 2 through 8)			0	0	0	9.00
10.00	SUBPROVIDER - IPF						10.00
11.00	SUBPROVIDER - IRF						11.00
12.00	SUBPROVIDER						12.00
13.00	SKILLED NURSING FACILITY	0	0	0	0	0	13.00
14.00	NURSING FACILITY						14.00
15.00	OTHER LONG TERM CARE						15.00
16.00	HOME HEALTH AGENCY						16.00
17.00	CMHC						17.00
18.00	AMBULATORY SURGICAL CENTER (D.P.)						18.00
19.00	HOSPICE						19.00
20.00	Subtotal (sum of lines 9 through 19)						20.00

	Cost Center Description	Titles V and XIX Outpatient and Title XVIII Part B Charges: Title XVIII Part B	Titles V and XIX Outpatient and Title XVIII Part B Charges: Title XIX	Titles V and XIX Outpatient and Title XVIII Part B Cost: Title V	Titles V and XIX Outpatient and Title XVIII Part B Cost: Title XVIII Part B	Titles V and XIX Outpatient and Title XVIII Part B Cost: Title XIX	
		6.00	7.00	8.00	9.00	10.00	
	Hospital Outpatient Services:						
21.00	RURAL HEALTH CLINIC						21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER						22.00
23.00	CLINIC	0	0	0	0	0	23.00
24.00	EMERGENCY	0	0	0	0	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)						25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER						26.00
27.00	Subtotal (sum of lines 21 through 26)			0	0	0	27.00
28.00	Total (sum of lines 20 and 27)						28.00

	Cost Center Description	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents		
		6.00	7.00	11.00		
	PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)					
	Hospital Inpatient Routine Services:					
29.00	ADULTS & PEDIATRICS	0	0	0		29.00
30.00	Swing Bed - SNF	0	0			30.00
31.00	Swing Bed - NF					31.00
32.00	INTENSIVE CARE UNIT	0	0	0		32.00
33.00	CORONARY CARE UNIT					33.00
34.00	BURN INTENSIVE CARE UNIT					34.00
35.00	SURGICAL INTENSIVE CARE UNIT					35.00
36.00	OTHER SPECIAL CARE (SPECIFY)					36.00
37.00	Subtotal (sum of lines 28, and 29 through 36)		0	0		37.00
38.00	SUBPROVIDER - IPF					38.00
39.00	SUBPROVIDER - IRF					39.00
40.00	SUBPROVIDER					40.00
41.00	SKILLED NURSING FACILITY	0	0	0		41.00
42.00	Total (sum of lines 37 through 41)		0	0		42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D-2 | Date/Time Prepared: 1/29/2014 11:45 am

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D-3 | Date/Time Prepared: 1/29/2014 11:45 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		36,472,788		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.784233	925,028	725,437	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182190	1,896,161	345,462	54.00
60.00	06000	LABORATORY	0.101892	7,735,022	788,137	60.00
65.00	06500	RESPIRATORY THERAPY	0.136598	15,386,086	2,101,709	65.00
66.00	06600	PHYSICAL THERAPY	0.426144	3,095,401	1,319,087	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	0.285193	7,241,024	2,065,089	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.128501	19,446,131	2,498,847	73.00
74.00	07400	RENAL DIALYSIS	0.414080	2,093,219	866,760	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)		57,818,072	10,710,528	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)		57,818,072		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet D-3 | Date/Time Prepared: 1/29/2014 11:45 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		68,801,574		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.784233	1,196,049	937,981	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182190	2,542,102	463,146	54.00
60.00	06000	LABORATORY	0.101286	9,536,282	965,892	60.00
65.00	06500	RESPIRATORY THERAPY	0.136598	28,615,866	3,908,870	65.00
66.00	06600	PHYSICAL THERAPY	0.426144	4,457,510	1,899,541	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	0.285193	12,572,248	3,585,517	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.128501	35,410,785	4,550,321	73.00
74.00	07400	RENAL DIALYSIS	0.414080	1,344,466	556,716	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)		95,675,308	16,867,984	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)		95,675,308		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 142008	Period: From 09/01/2012 To 08/31/2013	Worksheet E Part B Date/Time Prepared: 1/29/2014 11:45 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	779,760	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	779,760	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,916,940	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	2,916,940	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 chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	2,916,940	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,137,180	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)	779,760	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	583,471	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	196,289	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)	196,289	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	196,289	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)	196,289	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	196,289	40.00
40.01	Sequestration adjustment (see instructions)	1,649	40.01
41.00	Interim payments	189,194	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	5,446	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
		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 1/29/2014 11:45 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		27,373,149		189,194	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	11/27/2012	276,400		0	3.01
3.02		06/03/2013	936,100		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	12/02/2013	1,216,800		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)		-4,300		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)		27,368,849		189,194	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		70,481		5,446	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		27,439,330		194,640	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 142008	Period: From 09/01/2012 To 08/31/2013	Worksheet E-3 Part IV Date/Time Prepared: 1/29/2014 11:45 am
	Title XVIII	Hospital	PPS

		1.00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS		
1.00	Net Federal PPS Payments (see instructions)	28,359,453	1.00
2.00	Outlier Payments	814,058	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)	29,173,511	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)		5.00
6.00	Cost of teaching physicians	0	6.00
7.00	Subtotal (see instructions)	29,173,511	7.00
8.00	Primary payer payments	0	8.00
9.00	Subtotal (line 7 less line 8).	29,173,511	9.00
10.00	Deductibles	65,660	10.00
11.00	Subtotal (line 9 minus line 10)	29,107,851	11.00
12.00	Coinsurance	2,691,002	12.00
13.00	Subtotal (line 11 minus line 12)	26,416,849	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1,792,749	14.00
15.00	Adjusted reimbursable bad debts (see instructions)	1,254,924	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,692,688	16.00
17.00	Subtotal (sum of lines 13 and 15)	27,671,773	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)	27,671,773	22.00
22.01	Sequestration adjustment (see instructions)	232,443	22.01
23.00	Interim payments	27,368,849	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)	70,481	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: 142008	Period: From 09/01/2012 To 08/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 1/29/2014 11:45 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	44,052,903		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)	44,052,903	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)	44,052,903	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	68,801,574		8.00
9.00	Ancillary service charges	95,675,308	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)	164,476,882	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)	164,476,882	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	120,423,979	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)	44,052,903	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)	44,052,903	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)	44,052,903	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	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)	44,052,903	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)	44,052,903	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)	44,052,903	0	40.00
41.00	Interim payments	34,582,939	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	9,469,964	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: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet G | Date/Time Prepared: 1/29/2014 11:45 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	286,979	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	27,767,199	0	0	0	4.00
5.00	Other receivable	320	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,704,819	0	0	0	6.00
7.00	Inventory	606,802	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	25,956,481	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	675,156	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	31,090	0	0	0	15.00
16.00	Accumulated depreciation	-31,090	0	0	0	16.00
17.00	Leasehold improvements	30,961,485	0	0	0	17.00
18.00	Accumulated depreciation	-26,833,621	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	14,488,356	0	0	0	23.00
24.00	Accumulated depreciation	-10,769,845	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)	8,521,531	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	328,606	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	328,606	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	34,806,618	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,886,417	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,300,143	0	0	0	38.00
39.00	Payroll taxes payable	74,729	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				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,969,591	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,230,880	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	-72,973,724	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	-72,973,724	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	-66,742,844	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	101,549,462				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)	101,549,462	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	34,806,618	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet G-1 | Date/Time Prepared: 1/29/2014 11:45 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		99,723,031		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,826,430				2.00
3.00	Total (sum of line 1 and line 2)		101,549,461		0		3.00
4.00	Additions (credit adjustments)	0		0		0	4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	1		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		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)		101,549,462		0		11.00
12.00	Deductions (debit adjustments)	0		0		0	12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		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)		101,549,462		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/29/2014 11:45 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	125,807,525		125,807,525	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)	125,807,525		125,807,525	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)	125,807,525		125,807,525	17.00
18.00	Ancillary services	190,655,948	0	190,655,948	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)	316,463,473	0	316,463,473	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		89,422,117		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)		89,422,117		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 142008 | Period: From 09/01/2012 To 08/31/2013 | Worksheet G-3 | Date/Time Prepared: 1/29/2014 11:45 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	316,463,473	1.00
2.00	Less contractual allowances and discounts on patients' accounts	225,535,380	2.00
3.00	Net patient revenues (line 1 minus line 2)	90,928,093	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	89,422,117	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,505,976	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	5,638	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	124,557	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	73	17.00
18.00	Revenue from sale of medical records and abstracts	10,832	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	179,354	24.00
25.00	Total other income (sum of lines 6-24)	320,454	25.00
26.00	Total (line 5 plus line 25)	1,826,430	26.00
27.00	OTHER EXPENSES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,826,430	29.00