

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: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet S Parts I-III Date/Time Prepared: 1/13/2016 2:41 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 1/13/2016 Time: 2:41 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Kindred Hospital Indianapolis (152007) for the cost reporting period beginning 09/01/2014 and ending 08/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title XVIII		HIT	Title XIX		
	Title V	Part A				Part B
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-6,824	2,249	0	893,362	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
200.00 Total	0	-6,824	2,249	0	893,362	200.00

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

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

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152007		Period: From 09/01/2014 To 08/31/2015		Worksheet S-2 Part I Date/Time Prepared: 1/13/2016 1:42 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1700 West 10th Street		PO Box:								
2.00	City: Indianapolis		State: IN		Zip Code: 46222		County: Marion				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
		Hospital and Hospital-Based Component Identification:									
3.00	Hospital		Kindred Hospital Indianapolis		152007	26900	2	02/01/1994	N	P	O
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
								From:	To:		
								1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)							09/01/2014	08/31/2015		
21.00	Type of Control (see instructions)							4			
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.							N	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)							N	N		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.							N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.							N	N		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							2	N		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	0		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet S-2 Part I Date/Time Prepared: 1/13/2016 1:42 pm		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		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 is in effect in the cost reporting period.	0				37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the 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)	N		N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00
		V	XVII	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		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 Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	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		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	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 Wkst. D, Parts III & IV and D-2, Pt. 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, chapter 21, §2148? If yes, complete Wkst. D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. 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
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	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	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider 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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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		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 nonprovider 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	
		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
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) 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, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (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
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
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
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.				N	87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID 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

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		V		XIX			
		1.00		2.00			
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	
107.00	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 is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.					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		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.				N	110.00	
					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 column 1 is 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 hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §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:	75,057	0	237,005		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	
DO NOT USE THIS LINE							
119.00	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		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 2, "Y" for yes or "N" for no.					120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00	
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet S-2 Part I Date/Time Prepared: 1/13/2016 1:42 pm		
		1.00	2.00			
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		
		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 OPERATING 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		
				1.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00		
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, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00		
				1.00		
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
		1.00		2.00		3.00
						Title XIX
						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
156.00	Subprovider - IPF	N		N		N
157.00	Subprovider - IRF	N		N		N
158.00	SUBPROVIDER					
159.00	SNF	N		N		N
160.00	HOME HEALTH AGENCY	N		N		N
161.00	CMHC			N		N
				1.00		
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00		
		Name		County		State
		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 (see instructions)					0.00
166.01						0.00
166.02						0.00
166.03						0.00
				1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under §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		
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01		
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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet S-2 Part I Date/Time Prepared: 1/13/2016 1:42 pm
			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
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			171.00
			N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet S-2 Part II Date/Time Prepared: 1/13/2016 1:42 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/31/2016	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 Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/30/2015	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: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet S-2
Part II
Date/Time Prepared:
1/13/2016 1:42 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
1.00					
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2015	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 OPERATING INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5025967856	Daniel.Hourigan@kindred.com		43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	11/30/2015		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 DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
1/13/2016 1:42 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	
	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	59	21,535	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)		59	21,535	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)		59	21,535	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)		59				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
1/13/2016 1:42 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,374	712	8,889			1.00
2.00 HMO and other (see instructions)	575	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	5,374	712	8,889			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)	5,374	712	8,889	0.00	82.90	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	82.90	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	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	110					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
1/13/2016 1:42 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	193	24	315	1.00
2.00 HMO and other (see instructions)				19	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		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		193	24	315	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY	0.00						19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION				Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet S-3 Part II Date/Time Prepared: 1/13/2016 1:42 pm		
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	5,295,839	0	5,295,839	172,577.20	30.69	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	34,550	34,550	677.00	51.03	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		1,652,483	0	1,652,483	30,029.00	55.03	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		542,404	0	542,404	6,582.00	82.41	13.00
14.00	Home office salaries & wage-related costs		716,463	0	716,463	15,921.40	45.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		756,114	0	756,114			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		4,965	0	4,965			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	34,701	0	34,701	1,119.00	31.01	26.00
27.00	Administrative & General	5.00	788,828	0	788,828	17,797.20	44.32	27.00
28.00	Administrative & General under contract (see inst.)		4,095	0	4,095	47.00	87.13	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	28	0	28	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	85,326	0	85,326	7,833.00	10.89	32.00
33.00	Housekeeping under contract (see instructions)		3,596	0	3,596	258.00	13.94	33.00
34.00	Dietary	10.00	67,841	0	67,841	2,145.00	31.63	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	531,437	0	531,437	12,890.00	41.23	38.00
39.00	Central Services and Supply	14.00	76,073	0	76,073	3,970.00	19.16	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet S-3
Part II
Date/Time Prepared:
1/13/2016 1:42 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 258,397	0	258,397	8,158.00	31.67	41.00
42.00	Social Service	17.00 205,512	-34,550	170,962	3,350.00	51.03	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet S-3
Part III
Date/Time Prepared:
1/13/2016 1:42 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	5,303,530	0	5,303,530	172,882.20	30.68	1.00
2.00	Excluded area salaries (see instructions)	0	34,550	34,550	677.00	51.03	2.00
3.00	Subtotal salaries (line 1 minus line 2)	5,303,530	-34,550	5,268,980	172,205.20	30.60	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,911,350	0	2,911,350	52,532.40	55.42	4.00
5.00	Subtotal wage-related costs (see inst.)	756,114	0	756,114	0.00	14.35	5.00
6.00	Total (sum of lines 3 thru 5)	8,970,994	-34,550	8,936,444	224,737.60	39.76	6.00
7.00	Total overhead cost (see instructions)	2,055,834	-34,550	2,021,284	57,567.20	35.11	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet S-3 Part IV Date/Time Prepared: 1/13/2016 1:42 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		0	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)		275,220	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		-3,436	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		4,093	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)		23,620	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		69,165	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		335,114	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		39,863	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		12,475	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		756,114	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: 152007		Period: From 09/01/2014 To 08/31/2015		Worksheet A	
Date/Time Prepared: 1/13/2016 1:42 pm							
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		2,225,823	2,225,823	58,155	2,283,978	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		368,131	368,131	90,151	458,282	2.00
3.00 00300	OTHER CAP REL COSTS		148,306	148,306	-148,306	0	3.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	34,701	831,161	865,862	0	865,862	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	788,828	2,604,905	3,393,733	0	3,393,733	5.00
7.00 00700	OPERATION OF PLANT	28	938,618	938,646	0	938,646	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	64,203	64,203	0	64,203	8.00
9.00 00900	HOUSEKEEPING	85,326	102,320	187,646	0	187,646	9.00
10.00 01000	DIETARY	67,841	469,546	537,387	0	537,387	10.00
11.00 01100	CAFETERIA	0	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	531,437	4,639	536,076	0	536,076	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	76,073	5,702	81,775	0	81,775	14.00
15.00 01500	PHARMACY	0	856,945	856,945	0	856,945	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	258,397	49,312	307,709	0	307,709	16.00
17.00 01700	SOCIAL SERVICE	205,512	13,798	219,310	-36,870	182,440	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	2,478,670	1,063,481	3,542,151	0	3,542,151	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	64,654	293,871	358,525	0	358,525	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	90,376	77,514	167,890	0	167,890	54.00
60.00 06000	LABORATORY	25,471	300,374	325,845	0	325,845	60.00
65.00 06500	RESPIRATORY THERAPY	588,525	14,080	602,605	0	602,605	65.00
66.00 06600	PHYSICAL THERAPY	0	731,613	731,613	0	731,613	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	505,948	505,948	0	505,948	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	678,030	678,030	0	678,030	73.00
74.00 07400	RENAL DIALYSIS	0	291,136	291,136	0	291,136	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 09850	OTHER REIMBURSABLE CC'S	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,295,839	12,639,456	17,935,295	-36,870	17,898,425	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	36,870	36,870	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	CENTRALIZED ADMINISTRATIONS DEPT	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 CC'S	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)	5,295,839	12,639,456	17,935,295	0	17,935,295	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet A
Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	43,623	2,327,601	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	44,839	503,121	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,700	864,162	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-316,506	3,077,227	5.00
7.00	00700	OPERATION OF PLANT	-686	937,960	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	64,203	8.00
9.00	00900	HOUSEKEEPING	0	187,646	9.00
10.00	01000	DIETARY	-16,901	520,486	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	536,076	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	81,775	14.00
15.00	01500	PHARMACY	0	856,945	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,156	315,865	16.00
17.00	01700	SOCIAL SERVICE	0	182,440	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-112,072	3,430,079	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	-45,066	313,459	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-28,416	139,474	54.00
60.00	06000	LABORATORY	-3,244	322,601	60.00
65.00	06500	RESPIRATORY THERAPY	170	602,775	65.00
66.00	06600	PHYSICAL THERAPY	-49,400	682,213	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	505,948	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	678,030	73.00
74.00	07400	RENAL DIALYSIS	3,133	294,269	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	09850	OTHER REIMBURSABLE CC'S	0	0	98.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-474,070	17,424,355	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	36,870	194.00
194.01	07951	IDLE SPACE	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	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 CC'S	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	194.11
200.00		TOTAL (SUM OF LINES 118-199)	-474,070	17,461,225	200.00

RECLASSIFICATIONS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet A-6
Date/Time Prepared:
1/13/2016 1:42 pm

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
A - RECLASS NON ALLOWABLE CASE MANAGER						
1.00	NONALLOWABLE CASE MANAGER		194.00	34,550	2,320	1.00
TOTALS				34,550	2,320	
500.00	Grand Total: Increases			34,550	2,320	500.00

RECLASSIFICATIONS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet A-6

Date/Time Prepared:
1/13/2016 1:42 pm

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - RECLASS NON ALLOWABLE CASE MANAGER							
1.00	SOCIAL SERVICE	17.00	34,550	2,320	0		1.00
TOTALS			34,550	2,320			
500.00	Grand Total: Decreases		34,550	2,320			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet A-7
Part I
Date/Time Prepared:
1/13/2016 1:42 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	2,591,037	78,539	0	78,539	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	3,744,939	442,784	0	442,784	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	6,335,976	521,323	0	521,323	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	6,335,976	521,323	0	521,323	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	2,669,576	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	4,138,343	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	6,807,919	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	6,807,919	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet A-7
Part II
Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	20,369	2,205,454	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	215,058	153,073	0	0	0	2.00
3.00	Total (sum of lines 1-2)	235,427	2,358,527	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	2,225,823				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	368,131				2.00
3.00	Total (sum of lines 1-2)	0	2,593,954				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet A-7
Part III
Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	2,669,576	0	2,669,576	0.392128	9,689	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,138,343	0	4,138,343	0.607872	15,020	2.00
3.00	Total (sum of lines 1-2)	6,807,919	0	6,807,919	1.000000	24,709	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	48,466	0	58,155	72,887	2,205,454	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	75,131	0	90,151	259,897	153,073	2.00
3.00	Total (sum of lines 1-2)	123,597	0	148,306	332,784	2,358,527	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	794	48,466	0	2,327,601	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	15,020	75,131	0	503,121	2.00
3.00	Total (sum of lines 1-2)	0	15,814	123,597	0	2,830,722	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet A-8

Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-1,313		ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-24,719		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-686		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	-222,756				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	300,789				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-16,804		DIETARY	10.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-538		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines	B	-97		DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00			0		0.00	0	33.00
33.01 MISCELLANEOUS INCOME	B	-3,644		ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet A-8

Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center		Line #		
			1.00	2.00	3.00		4.00
33.02		0			0.00	0	33.02
33.03		0			0.00	0	33.03
33.04		0			0.00	0	33.04
33.05	OCCUPATIONAL INCENTIVE INCOME	-24,612	ADMINISTRATIVE & GENERAL		5.00	0	33.05
33.06		0			0.00	0	33.06
33.07		0			0.00	0	33.07
33.08	MEDICARE BAD DEBT - PART A	-500,649	ADMINISTRATIVE & GENERAL		5.00	0	33.08
33.09		0			0.00	0	33.09
33.10	OTHER MEDICARE NON ALLOWABLE	-22,164	ADMINISTRATIVE & GENERAL		5.00	0	33.10
33.11		0			0.00	0	33.11
33.12	OTHER OPERATING - PUBLIC RELATIONS	-323	ADMINISTRATIVE & GENERAL		5.00	0	33.12
33.13	OTHER OPERATING - MARKETING	-14,581	ADMINISTRATIVE & GENERAL		5.00	0	33.13
33.14		0			0.00	0	33.14
33.15		0			0.00	0	33.15
33.16		0			0.00	0	33.16
33.17		0			0.00	0	33.17
33.18		0			0.00	0	33.18
33.19		0			0.00	0	33.19
33.20		0			0.00	0	33.20
33.21		0			0.00	0	33.21
33.22		0			0.00	0	33.22
33.23		0			0.00	0	33.23
33.24		0			0.00	0	33.24
33.25		0			0.00	0	33.25
33.26		0			0.00	0	33.26
33.27		0			0.00	0	33.27
33.28	AGGREGATE CAPITAL EROSION	-29,009	ADMINISTRATIVE & GENERAL		5.00	0	33.28
33.29	CABLE TV AND SATELLITE	-9,326	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	35,700	ADMINISTRATIVE & GENERAL		5.00	0	33.32
33.33		0			0.00	0	33.33
33.34	MALPRACTICE TAIL LIABILITY	-5,250	ADMINISTRATIVE & GENERAL		5.00	0	33.34
33.35		0			0.00	0	33.35
33.36		0			0.00	0	33.36
33.37	PHYSICIAN BILLING COLLECTION FEES	-803	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	40,305	CAP REL COSTS-BLDG & FIXT		1.00	9	34.00
34.01	MEDICARE VS BOOK MOV EQUIP	-39,646	CAP REL COSTS-MVBLE EQUIP		2.00	9	34.01
34.02	ASSET ADD-ON BLDG	12,595	CAP REL COSTS-BLDG & FIXT		1.00	9	34.02
34.03	ASSET ADD-ON MOV EQUIP	84,485	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	-2,027	ADMINISTRATIVE & GENERAL		5.00	0	34.06
34.07		0			0.00	0	34.07
34.08	BUSINESS INTERRUPTIONS INS PREMIUM	-8,895	CAP REL COSTS-BLDG & FIXT		1.00	12	34.08
34.09		0			0.00	0	34.09
34.10		0			0.00	0	34.10
34.11		0			0.00	0	34.11
34.12		0			0.00	0	34.12
34.13		0			0.00	0	34.13
34.14		0			0.00	0	34.14
34.15		0			0.00	0	34.15
34.16	OVERSTMT DUE TO DIFF GAAP VS AHA	-382	CAP REL COSTS-BLDG & FIXT		1.00	9	34.16
34.17		0			0.00	0	34.17
34.18		0			0.00	0	34.18
34.19		0			0.00	0	34.19
34.20		0			0.00	0	34.20
34.21		0			0.00	0	34.21
34.22	DISTRICT OFFICE SALES AND MARKETING	-18,021	ADMINISTRATIVE & GENERAL		5.00	0	34.22
34.23	DISTRICT OFC SALES AND MKT BENEFITS	-1,700	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	34.23

ADJUSTMENTS TO EXPENSES

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet A-8

Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00		3.00	4.00
34.24		0			0.00	0	34.24
34.25		0			0.00	0	34.25
34.26		0			0.00	0	34.26
34.27		0			0.00	0	34.27
34.28		0			0.00	0	34.28
35.00		0			0.00	0	35.00
35.01	PHYSICIAN FEE ADJUSTMENT	A	-45,954	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02			0		0.00	0	35.02
35.03			0		0.00	0	35.03
35.04			0		0.00	0	35.04
35.05			0		0.00	0	35.05
35.06			0		0.00	0	35.06
35.07			0		0.00	0	35.07
35.08			0		0.00	0	35.08
35.09	PHYSICIAN FEE ADJUSTMENT	A	8,694	MEDICAL RECORDS & LIBRARY	16.00	0	35.09
35.10			0		0.00	0	35.10
35.11	PHYSICIAN FEE ADJUSTMENT	A	-27,634	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	PHYSICIAN FEE ADJUSTMENT	A	41,620	RESPIRATORY THERAPY	65.00	0	35.17
35.18			0		0.00	0	35.18
35.19			0		0.00	0	35.19
35.20			0		0.00	0	35.20
35.21	PHYSICIAN FEE ADJUSTMENT	A	23,275	RENAL DIALYSIS	74.00	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.)		-474,070				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 152007

Period: From 09/01/2014 To 08/31/2015

Worksheet A-8-1

Date/Time Prepared: 1/13/2016 1:42 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	1,197,314	847,125 1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	Workers Comp Premium	67,278	67,278 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	259,838	259,838 3.00
4.00	0.00			0	0 4.00
4.01	66.00	PHYSICAL THERAPY	Therapy Services	673,021	722,421 4.01
5.00	0			2,197,451	1,896,662 5.00

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

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

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

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

6.00	B	KH01	100.00	Admin & Gen	100.00	6.00
7.00	B	KH01	100.00	Cornerstone	100.00	7.00
8.00	B	KH01	100.00	Cornerstone	100.00	8.00
9.00			0.00		0.00	9.00
10.00	B	KH01	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: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet A-8-1

Date/Time Prepared:
1/13/2016 1:42 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	350,189	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	-49,400	0		4.01
5.00	300,789			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: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet A-8-2

Date/Time Prepared:
1/13/2016 1:42 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	65.00	DR. A	41,080	41,080	0	177,200	0	1.00
2.00	30.00	DR. B	463,780	0	463,780	177,200	6,184	2.00
3.00	30.00	DR. C	10,388	0	10,388	177,200	69	3.00
4.00	30.00	DR. D	3,150	0	3,150	177,200	21	4.00
5.00	54.00	DR. E	28,416	28,416	0	225,300	0	5.00
6.00	65.00	DR. F	540	0	540	177,200	2	6.00
7.00	50.00	DR. G	45,066	45,066	0	208,000	0	7.00
8.00	30.00	DR. H	11,206	11,206	0	177,200	0	8.00
9.00	74.00	DR. I	23,275	0	23,275	177,200	123	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	74.00	DR. K	13,395	0	13,395	177,200	71	11.00
12.00	60.00	DR. L	6,770	0	6,770	215,700	34	12.00
13.00	30.00	DR. M	38,740	38,740	0	177,200	0	13.00
14.00	30.00	DR. N	4,043	0	4,043	177,200	25	14.00
16.00	30.00	DR. P	26,708	26,708	0	177,200	0	16.00
200.00			716,557	191,216	525,341		6,529	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	65.00	DR. A	0	0	0	0	0	1.00
2.00	30.00	DR. B	526,829	26,341	0	0	0	2.00
3.00	30.00	DR. C	5,878	294	0	0	0	3.00
4.00	30.00	DR. D	1,789	89	0	0	0	4.00
5.00	54.00	DR. E	0	0	0	0	0	5.00
6.00	65.00	DR. F	170	9	0	0	0	6.00
7.00	50.00	DR. G	0	0	0	0	0	7.00
8.00	30.00	DR. H	0	0	0	0	0	8.00
9.00	74.00	DR. I	10,479	524	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	74.00	DR. K	6,049	302	0	0	0	11.00
12.00	60.00	DR. L	3,526	176	0	0	0	12.00
13.00	30.00	DR. M	0	0	0	0	0	13.00
14.00	30.00	DR. N	2,130	107	0	0	0	14.00
16.00	30.00	DR. P	0	0	0	0	0	16.00
200.00			556,850	27,842	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	65.00	DR. A	0	0	0	41,080		1.00
2.00	30.00	DR. B	0	526,829	0	0		2.00
3.00	30.00	DR. C	0	5,878	4,510	4,510		3.00
4.00	30.00	DR. D	0	1,789	1,361	1,361		4.00
5.00	54.00	DR. E	0	0	0	28,416		5.00
6.00	65.00	DR. F	0	170	370	370		6.00
7.00	50.00	DR. G	0	0	0	45,066		7.00
8.00	30.00	DR. H	0	0	0	11,206		8.00
9.00	74.00	DR. I	0	10,479	12,796	12,796		9.00
10.00	0.00		0	0	0	0		10.00
11.00	74.00	DR. K	0	6,049	7,346	7,346		11.00
12.00	60.00	DR. L	0	3,526	3,244	3,244		12.00
13.00	30.00	DR. M	0	0	0	38,740		13.00
14.00	30.00	DR. N	0	2,130	1,913	1,913		14.00
16.00	30.00	DR. P	0	0	0	26,708		16.00
200.00			0	556,850	31,540	222,756		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet B
Part I
Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,327,601	2,327,601			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	503,121		503,121		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	864,162	34,135	7,378	905,675	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,077,227	168,584	36,440	135,792	5.00
7.00 00700	OPERATION OF PLANT	937,960	306,731	66,301	5	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	64,203	36,225	7,830	0	8.00
9.00 00900	HOUSEKEEPING	187,646	56,534	12,220	14,688	9.00
10.00 01000	DIETARY	520,486	193,931	41,919	11,678	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	536,076	19,023	4,112	91,484	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	81,775	103,744	22,425	13,096	14.00
15.00 01500	PHARMACY	856,945	44,048	9,521	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	315,865	18,541	4,008	44,481	16.00
17.00 01700	SOCIAL SERVICE	182,440	7,931	1,714	29,430	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,430,079	980,910	212,029	426,689	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	313,459	108,889	23,537	11,130	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	139,474	53,212	11,502	15,558	54.00
60.00 06000	LABORATORY	322,601	43,673	9,440	4,385	60.00
65.00 06500	RESPIRATORY THERAPY	602,775	46,513	10,054	101,311	65.00
66.00 06600	PHYSICAL THERAPY	682,213	94,420	20,409	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	505,948	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	678,030	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	294,269	10,557	2,282	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE CC'S	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	17,424,355	2,327,601	503,121	899,727	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CASE MANAGER	36,870	0	0	5,948	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07 07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE CC'S	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	17,461,225	2,327,601	503,121	905,675	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet B
Part I
Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,418,043				5.00
7.00	00700	OPERATION OF PLANT	319,090	1,630,087			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,349	32,478	167,085		8.00
9.00	00900	HOUSEKEEPING	65,981	50,686	0	387,755	9.00
10.00	01000	DIETARY	186,931	173,871	0	43,583	1,172,399
11.00	01100	CAFETERIA	0	0	0	0	345,146
13.00	01300	NURSING ADMINISTRATION	158,376	17,056	0	4,275	0
14.00	01400	CENTRAL SERVICES & SUPPLY	53,800	93,013	0	23,315	0
15.00	01500	PHARMACY	221,615	39,492	0	9,899	0
16.00	01600	MEDICAL RECORDS & LIBRARY	93,195	16,623	0	4,167	0
17.00	01700	SOCIAL SERVICE	53,916	7,111	0	1,782	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,229,076	879,446	167,085	220,445	732,753
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	111,235	97,626	0	24,471	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,485	47,708	0	11,959	0
60.00	06000	LABORATORY	92,514	39,156	0	9,815	0
65.00	06500	RESPIRATORY THERAPY	185,139	41,702	0	10,453	0
66.00	06600	PHYSICAL THERAPY	193,996	84,654	0	21,219	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	123,145	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	165,029	0	0	0	0
74.00	07400	RENAL DIALYSIS	74,749	9,465	0	2,372	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE CC'S	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,407,621	1,630,087	167,085	387,755	1,077,899
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	10,422	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0	0
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0
194.07	07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09	07958	VISITOR MEALS	0	0	0	0	94,500
194.10	07962	OTHER NONREIMBURSABLE CC'S	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,418,043	1,630,087	167,085	387,755	1,172,399

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet B
Part I
Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	345,146					11.00
13.00	01300	29,584	859,986				13.00
14.00	01400	9,861	0	401,029			14.00
15.00	01500	0	0	7,082	1,188,602		15.00
16.00	01600	19,723	0	0	0	516,603	16.00
17.00	01700	9,861	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	212,017	840,441	33,525	37,325	141,265	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,931	19,545	0	0	11,723	50.00
54.00	05400	4,931	0	1,052	0	10,036	54.00
60.00	06000	4,931	0	8,126	0	48,428	60.00
65.00	06500	49,307	0	2,619	0	89,856	65.00
66.00	06600	0	0	5,857	0	27,882	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	341,977	0	63,677	71.00
73.00	07300	0	0	0	1,151,277	111,623	73.00
74.00	07400	0	0	791	0	12,113	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		345,146	859,986	401,029	1,188,602	516,603	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		345,146	859,986	401,029	1,188,602	516,603	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet B
Part I
Date/Time Prepared:
1/13/2016 1:42 pm

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	294,185				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	294,185	9,837,270	0	9,837,270	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	726,546	0	726,546	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	348,917	0	348,917	54.00
60.00	06000	LABORATORY	0	583,069	0	583,069	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,139,729	0	1,139,729	65.00
66.00	06600	PHYSICAL THERAPY	0	1,130,650	0	1,130,650	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	1,034,747	0	1,034,747	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,105,959	0	2,105,959	73.00
74.00	07400	RENAL DIALYSIS	0	406,598	0	406,598	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	09850	OTHER REIMBURSABLE CC'S	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	294,185	17,313,485	0	17,313,485	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	53,240	0	53,240	194.00
194.01	07951	IDLE SPACE	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	94,500	0	94,500	194.09
194.10	07962	OTHER NONREIMBURSABLE CC'S	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	294,185	17,461,225	0	17,461,225	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet B
Part II
Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	34,135	7,378	41,513	41,513 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	140,412	168,584	36,440	345,436	6,224 5.00
7.00 00700	OPERATION OF PLANT	0	306,731	66,301	373,032	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	36,225	7,830	44,055	0 8.00
9.00 00900	HOUSEKEEPING	0	56,534	12,220	68,754	673 9.00
10.00 01000	DIETARY	0	193,931	41,919	235,850	535 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	0	19,023	4,112	23,135	4,193 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	103,744	22,425	126,169	600 14.00
15.00 01500	PHARMACY	0	44,048	9,521	53,569	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	18,541	4,008	22,549	2,039 16.00
17.00 01700	SOCIAL SERVICE	0	7,931	1,714	9,645	1,349 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	980,910	212,029	1,192,939	19,560 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	108,889	23,537	132,426	510 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	53,212	11,502	64,714	713 54.00
60.00 06000	LABORATORY	0	43,673	9,440	53,113	201 60.00
65.00 06500	RESPIRATORY THERAPY	0	46,513	10,054	56,567	4,643 65.00
66.00 06600	PHYSICAL THERAPY	0	94,420	20,409	114,829	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	10,557	2,282	12,839	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 09850	OTHER REIMBURSABLE CC'S	0	0	0	0	0 98.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	140,412	2,327,601	503,121	2,971,134	41,240 118.00
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	273 194.00
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	CENTRALIZED ADMISSIONS DEPT	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 CC'S	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)	140,412	2,327,601	503,121	2,971,134	41,513 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet B Part II Date/Time Prepared: 1/13/2016 1:42 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	351,660				5.00	
7.00	00700	OPERATION OF PLANT	32,829	405,861			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	2,711	8,086	54,852		8.00	
9.00	00900	HOUSEKEEPING	6,788	12,620	0	88,835	9.00	
10.00	01000	DIETARY	19,232	43,291	0	9,985	308,893	10.00
11.00	01100	CAFETERIA	0	0	0	0	90,936	11.00
13.00	01300	NURSING ADMINISTRATION	16,294	4,247	0	979	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,535	23,159	0	5,341	0	14.00
15.00	01500	PHARMACY	22,800	9,833	0	2,268	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,588	4,139	0	955	0	16.00
17.00	01700	SOCIAL SERVICE	5,547	1,770	0	408	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	126,454	218,965	54,852	50,504	193,059	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	11,444	24,307	0	5,606	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,503	11,878	0	2,740	0	54.00
60.00	06000	LABORATORY	9,518	9,749	0	2,249	0	60.00
65.00	06500	RESPIRATORY THERAPY	19,048	10,383	0	2,395	0	65.00
66.00	06600	PHYSICAL THERAPY	19,959	21,077	0	4,861	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	12,669	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,979	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	7,690	2,357	0	544	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	09850	OTHER REIMBURSABLE CC'S	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	350,588	405,861	54,852	88,835	283,995	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	1,072	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	CENTRALIZED ADMINISTRATIONS DEPT	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	24,898	194.09
194.10	07962	OTHER NONREIMBURSABLE CC'S	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)	351,660	405,861	54,852	88,835	308,893	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 152007		Period: From 09/01/2014 To 08/31/2015		Worksheet B Part II Date/Time Prepared: 1/13/2016 1:42 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	90,936					11.00
13.00	01300	7,795	56,643				13.00
14.00	01400	2,598	0	163,402			14.00
15.00	01500	0	0	2,885	91,355		15.00
16.00	01600	5,196	0	0	0	44,466	16.00
17.00	01700	2,598	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	55,861	55,356	13,660	2,869	12,159	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,299	1,287	0	0	1,009	50.00
54.00	05400	1,299	0	429	0	864	54.00
60.00	06000	1,299	0	3,311	0	4,168	60.00
65.00	06500	12,991	0	1,067	0	7,734	65.00
66.00	06600	0	0	2,387	0	2,400	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	139,341	0	5,481	71.00
73.00	07300	0	0	0	88,486	9,608	73.00
74.00	07400	0	0	322	0	1,043	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		90,936	56,643	163,402	91,355	44,466	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		90,936	56,643	163,402	91,355	44,466	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet B Part II Date/Time Prepared: 1/13/2016 1:42 pm		
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	21,317			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,317	2,017,555	0	2,017,555
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	177,888	0	177,888
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	88,140	0	88,140
60.00	06000	LABORATORY	0	83,608	0	83,608
65.00	06500	RESPIRATORY THERAPY	0	114,828	0	114,828
66.00	06600	PHYSICAL THERAPY	0	165,513	0	165,513
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	157,491	0	157,491
73.00	07300	DRUGS CHARGED TO PATIENTS	0	115,073	0	115,073
74.00	07400	RENAL DIALYSIS	0	24,795	0	24,795
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE CC'S	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,317	2,944,891	0	2,944,891
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	1,345	0	1,345
194.01	07951	IDLE SPACE	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	24,898	0	24,898
194.10	07962	OTHER NONREIMBURSABLE CC'S	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,317	2,971,134	0	2,971,134

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet B-1
Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	43,436				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		43,436			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	637	637	5,261,138		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,146	3,146	788,828	-3,418,043	5.00
7.00 00700	OPERATION OF PLANT	5,724	5,724	28	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	676	676	0	0	8.00
9.00 00900	HOUSEKEEPING	1,055	1,055	85,326	0	9.00
10.00 01000	DIETARY	3,619	3,619	67,841	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	355	355	531,437	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,936	1,936	76,073	0	14.00
15.00 01500	PHARMACY	822	822	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	346	346	258,397	0	16.00
17.00 01700	SOCIAL SERVICE	148	148	170,962	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	18,305	18,305	2,478,670	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,032	2,032	64,654	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	993	993	90,376	0	54.00
60.00 06000	LABORATORY	815	815	25,471	0	60.00
65.00 06500	RESPIRATORY THERAPY	868	868	588,525	0	65.00
66.00 06600	PHYSICAL THERAPY	1,762	1,762	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	197	197	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE CC'S	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	43,436	43,436	5,226,588	-3,418,043	14,000,364
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CASE MANAGER	0	0	34,550	0	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07 07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE CC'S	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,327,601	503,121	905,675		3,418,043
203.00	Unit cost multiplier (Wkst. B, Part I)	53.586909	11.583042	0.172144		0.243395
204.00	Cost to be allocated (per Wkst. B, Part II)			41,513		351,660
205.00	Unit cost multiplier (Wkst. B, Part II)			0.007890		0.025041

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet B-1

Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	33,929				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	676	8,889			8.00
9.00	00900	HOUSEKEEPING	1,055	0	32,198		9.00
10.00	01000	DIETARY	3,619	0	3,619	36,971	10.00
11.00	01100	CAFETERIA	0	0	0	10,884	70 11.00
13.00	01300	NURSING ADMINISTRATION	355	0	355	0	6 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,936	0	1,936	0	2 14.00
15.00	01500	PHARMACY	822	0	822	0	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	346	0	346	0	4 16.00
17.00	01700	SOCIAL SERVICE	148	0	148	0	2 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,305	8,889	18,305	23,107	43 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	2,032	0	2,032	0	1 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	993	0	993	0	1 54.00
60.00	06000	LABORATORY	815	0	815	0	1 60.00
65.00	06500	RESPIRATORY THERAPY	868	0	868	0	10 65.00
66.00	06600	PHYSICAL THERAPY	1,762	0	1,762	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	197	0	197	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
98.00	09850	OTHER REIMBURSABLE CC'S	0	0	0	0	0 98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	33,929	8,889	32,198	33,991	70 118.00
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	CENTRALIZED ADMINISTRATIONS DEPT	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	2,980	0 194.09
194.10	07962	OTHER NONREIMBURSABLE CC'S	0	0	0	0	0 194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0 194.11
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,630,087	167,085	387,755	1,172,399	345,146 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.044063	18.796828	12.042829	31.711314	4,930.657143 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	405,861	54,852	88,835	308,893	90,936 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	11.962068	6.170773	2.759022	8.355008	1,299.085714 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet B-1
Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	44					13.00
14.00	01400	0	593,314				14.00
15.00	01500	0	10,477	700,012			15.00
16.00	01600	0	0	0	47,457,120		16.00
17.00	01700	0	0	0	0	8,889	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	43	49,599	21,982	12,978,165	8,889	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1	0	0	1,076,852	0	50.00
54.00	05400	0	1,557	0	921,930	0	54.00
60.00	06000	0	12,022	0	4,448,650	0	60.00
65.00	06500	0	3,875	0	8,254,313	0	65.00
66.00	06600	0	8,666	0	2,561,228	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	505,948	0	5,849,453	0	71.00
73.00	07300	0	0	678,030	10,253,805	0	73.00
74.00	07400	0	1,170	0	1,112,724	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		44	593,314	700,012	47,457,120	8,889	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00							201.00
202.00		859,986	401,029	1,188,602	516,603	294,185	202.00
203.00		19,545.136364	0.675914	1.697974	0.010886	33.095399	203.00
204.00		56,643	163,402	91,355	44,466	21,317	204.00
205.00		1,287.340909	0.275406	0.130505	0.000937	2.398133	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet C Part I Date/Time Prepared: 1/13/2016 1:42 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		9,837,270	7,784	9,845,054	30.00
31.00	03100 INTENSIVE CARE UNIT		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		726,546	0	726,546	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		348,917	0	348,917	54.00
60.00	06000 LABORATORY		583,069	3,244	586,313	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,139,729	370	1,140,099	65.00
66.00	06600 PHYSICAL THERAPY	0	1,130,650	0	1,130,650	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		1,034,747	0	1,034,747	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,105,959	0	2,105,959	73.00
74.00	07400 RENAL DIALYSIS		406,598	20,142	426,740	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0	0	0	90.00
91.00	09100 EMERGENCY		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE CC'S		0	0	0	98.00
200.00	Subtotal (see instructions)		17,313,485	31,540	17,345,025	200.00
201.00	Less Observation Beds		0	0	0	201.00
202.00	Total (see instructions)		17,313,485	31,540	17,345,025	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet C
Part I
Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,978,165		12,978,165		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	1,076,852	0	1,076,852	0.674694	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	921,930	0	921,930	0.378464	54.00
60.00	06000	LABORATORY	4,448,650	0	4,448,650	0.131067	60.00
65.00	06500	RESPIRATORY THERAPY	8,254,313	0	8,254,313	0.138077	65.00
66.00	06600	PHYSICAL THERAPY	2,561,228	0	2,561,228	0.441448	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,849,453	0	5,849,453	0.176896	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,253,805	0	10,253,805	0.205383	73.00
74.00	07400	RENAL DIALYSIS	1,112,724	0	1,112,724	0.365408	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE CC'S	0	0	0	0.000000	98.00
200.00		Subtotal (see instructions)	47,457,120	0	47,457,120		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	47,457,120	0	47,457,120		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet C Part I Date/Time Prepared: 1/13/2016 1:42 pm
		Title XVIII	Hospital	PPS

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	0.674694	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.378464	54.00
60.00	06000 LABORATORY	0.131796	60.00
65.00	06500 RESPIRATORY THERAPY	0.138122	65.00
66.00	06600 PHYSICAL THERAPY	0.441448	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	0.176896	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.205383	73.00
74.00	07400 RENAL DIALYSIS	0.383509	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	09850 OTHER REIMBURSABLE CC'S	0.000000	98.00
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: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet C Part I Date/Time Prepared: 1/13/2016 1:42 pm
		Title XIX	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		9,837,270	7,784	9,845,054	30.00
31.00	03100 INTENSIVE CARE UNIT		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		726,546	0	726,546	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		348,917	0	348,917	54.00
60.00	06000 LABORATORY		583,069	3,244	586,313	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,139,729	370	1,140,099	65.00
66.00	06600 PHYSICAL THERAPY	0	1,130,650	0	1,130,650	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		1,034,747	0	1,034,747	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,105,959	0	2,105,959	73.00
74.00	07400 RENAL DIALYSIS		406,598	20,142	426,740	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0	0	0	90.00
91.00	09100 EMERGENCY		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE CC'S		0	0	0	98.00
200.00	Subtotal (see instructions)		17,313,485	31,540	17,345,025	200.00
201.00	Less Observation Beds		0	0	0	201.00
202.00	Total (see instructions)		17,313,485	31,540	17,345,025	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet C
Part I
Date/Time Prepared:
1/13/2016 1:42 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,978,165		12,978,165		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	1,076,852	0	1,076,852	0.674694	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	921,930	0	921,930	0.378464	54.00
60.00	06000	LABORATORY	4,448,650	0	4,448,650	0.131067	60.00
65.00	06500	RESPIRATORY THERAPY	8,254,313	0	8,254,313	0.138077	65.00
66.00	06600	PHYSICAL THERAPY	2,561,228	0	2,561,228	0.441448	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,849,453	0	5,849,453	0.176896	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,253,805	0	10,253,805	0.205383	73.00
74.00	07400	RENAL DIALYSIS	1,112,724	0	1,112,724	0.365408	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE CC'S	0	0	0	0.000000	98.00
200.00		Subtotal (see instructions)	47,457,120	0	47,457,120		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	47,457,120	0	47,457,120		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet C Part I Date/Time Prepared: 1/13/2016 1:42 pm
		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	09850 OTHER REIMBURSABLE CC'S	0.000000		98.00
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: 152007		Period: From 09/01/2014 To 08/31/2015		Worksheet D Part I Date/Time Prepared: 1/13/2016 1:42 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,017,555	0	2,017,555	8,889	226.97	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (Lines 30-199)	2,017,555		2,017,555	8,889		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	5,374	1,219,737				
31.00	INTENSIVE CARE UNIT	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (Lines 30-199)	5,374	1,219,737				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet D Part II Date/Time Prepared: 1/13/2016 1:42 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	177,888	1,076,852	0.165193	754,008	124,557	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	88,140	921,930	0.095604	495,860	47,406	54.00
60.00	06000 LABORATORY	83,608	4,448,650	0.018794	2,654,576	49,890	60.00
65.00	06500 RESPIRATORY THERAPY	114,828	8,254,313	0.013911	4,624,551	64,332	65.00
66.00	06600 PHYSICAL THERAPY	165,513	2,561,228	0.064623	1,460,974	94,413	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	157,491	5,849,453	0.026924	3,438,848	92,588	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	115,073	10,253,805	0.011222	5,900,941	66,220	73.00
74.00	07400 RENAL DIALYSIS	24,795	1,112,724	0.022283	672,861	14,993	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	09850 OTHER REIMBURSABLE CC'S	0	0	0.000000	0	0	98.00
200.00	Total (Lines 50-199)	927,336	34,478,955		20,002,619	554,399	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 152007		Period: From 09/01/2014 To 08/31/2015		Worksheet D Part III Date/Time Prepared: 1/13/2016 1:42 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,889	0.00	5,374	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	8,889		5,374	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet D
Part IV
Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE CC'S	0	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet D
Part IV
Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	1,076,852	0.000000	0.000000	754,008	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	921,930	0.000000	0.000000	495,860	54.00
60.00	06000 LABORATORY	0	4,448,650	0.000000	0.000000	2,654,576	60.00
65.00	06500 RESPIRATORY THERAPY	0	8,254,313	0.000000	0.000000	4,624,551	65.00
66.00	06600 PHYSICAL THERAPY	0	2,561,228	0.000000	0.000000	1,460,974	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,849,453	0.000000	0.000000	3,438,848	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	10,253,805	0.000000	0.000000	5,900,941	73.00
74.00	07400 RENAL DIALYSIS	0	1,112,724	0.000000	0.000000	672,861	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
98.00	09850 OTHER REIMBURSABLE CC'S	0	0	0.000000	0.000000	0	98.00
200.00	Total (Lines 50-199)	0	34,478,955			20,002,619	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet D
Part IV
Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description		Title XVIII			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0		95.00
98.00	09850 OTHER REIMBURSABLE CC'S	0	0	0		98.00
200.00	Total (Lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet D Part V Date/Time Prepared: 1/13/2016 1:42 pm
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
							1.00	2.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.674694	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.378464	0	28,560	0	0	54.00
60.00	06000	LABORATORY	0.131067	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.138077	0	54,300	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.441448	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	0.176896	0	501	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205383	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.365408	0	10,904	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	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE CC'S	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	94,265	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	94,265	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet D Part V Date/Time Prepared: 1/13/2016 1:42 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,809	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,498	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	89	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,984	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	09850	OTHER REIMBURSABLE CC'S	0	0	98.00
200.00		Subtotal (see instructions)	22,380	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	22,380	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet D-1 Date/Time Prepared: 1/13/2016 1:42 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,889	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,889	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		8,889	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)		5,374	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,845,054	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		9,845,054	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		9,845,054	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,107.55	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,951,974	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		5,951,974	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet D-1 Date/Time Prepared: 1/13/2016 1:42 pm
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0 43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,408,267 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,360,241 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,219,737 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					554,399 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,774,136 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,586,105 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/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID 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: 152007		Period: From 09/01/2014 To 08/31/2015		Worksheet D-1 Date/Time Prepared: 1/13/2016 1:42 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,017,555	9,845,054	0.204931	0	0	90.00
91.00	Nursing School cost	0	9,845,054	0.000000	0	0	91.00
92.00	Allied health cost	0	9,845,054	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,845,054	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet D-1 Date/Time Prepared: 1/13/2016 1:42 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			8,889 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			8,889 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			8,889 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)			712 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			9,837,270 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			9,837,270 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			9,837,270 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,106.68 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			787,956 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)			787,956 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152007		Period: From 09/01/2014 To 08/31/2015		Worksheet D-1 Date/Time Prepared: 1/13/2016 1:42 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	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							
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					612,431	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,400,387	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/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID 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: 152007		Period: From 09/01/2014 To 08/31/2015		Worksheet D-1 Date/Time Prepared: 1/13/2016 1:42 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,017,555	9,837,270	0.205093	0	0	90.00
91.00	Nursing School cost	0	9,837,270	0.000000	0	0	91.00
92.00	Allied health cost	0	9,837,270	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,837,270	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet D-2

Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program Inpatient Days Title V																																																																																																																															
	1.00	2.00	3.00	4.00	5.00																																																																																																																															
PART I - NOT IN APPROVED TEACHING PROGRAM																																																																																																																																				
Hospital Inpatient Routine Services:																																																																																																																																				
1.00 Total cost of services rendered	0.00	0				1.00																																																																																																																														
2.00 ADULTS & PEDIATRICS	0.00	0	8,889	0.00	0	2.00																																																																																																																														
3.00 INTENSIVE CARE UNIT	0.00	0	0	0.00	0	3.00																																																																																																																														
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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)																																																																																																																															
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APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet D-2

Date/Time Prepared:
1/13/2016 1:42 pm

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

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet D-2
Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description	Health Care Program Inpatient Days		Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
	Title XVIII, Part B Only Less Part A Coverage but no Part B Coverage	Title XIX				
	6.00	7.00				
PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00	Total cost of services rendered					1.00
Hospital Inpatient Routine Services:						
2.00	ADULTS & PEDIATRICS	5,374	712	0	0	0
3.00	INTENSIVE CARE UNIT	0	0	0	0	0
4.00	CORONARY CARE UNIT					
5.00	BURN INTENSIVE CARE UNIT					
6.00	SURGICAL INTENSIVE CARE UNIT					
7.00	OTHER SPECIAL CARE (SPECIFY)					
8.00	NURSERY					
9.00	Subtotal (sum of lines 2 through 8)			0	0	0
10.00	SUBPROVIDER - IPF					
11.00	SUBPROVIDER - IRF					
12.00	SUBPROVIDER					
13.00	SKILLED NURSING FACILITY	0	0	0	0	0
14.00	NURSING FACILITY					
15.00	OTHER LONG TERM CARE					
16.00	HOME HEALTH AGENCY					
17.00	CMHC					
18.00	AMBULATORY SURGICAL CENTER (D.P.)					
19.00	HOSPICE					
20.00	Subtotal (sum of lines 9 through 19)					
Cost Center Description		Titles V and XIX Outpatient and Title XVIII Part B Charges		Titles V and XIX Outpatient and Title XVIII Part B Cost		
		Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX
		6.00	7.00	8.00	9.00	10.00
Hospital Outpatient Services:						
21.00	RURAL HEALTH CLINIC					
22.00	FEDERALLY QUALIFIED HEALTH CENTER					
23.00	CLINIC	0	0	0	0	0
24.00	EMERGENCY	0	0	0	0	0
25.00	OBSERVATION BEDS (NON-DISTINCT PART)					
26.00	OTHER OUTPATIENT SERVICE COST CENTER					
27.00	Subtotal (sum of lines 21 through 26)			0	0	0
28.00	Total (sum of lines 20 and 27)					
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: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet D-2

Date/Time Prepared:
1/13/2016 1:42 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet D-3 Date/Time Prepared: 1/13/2016 1:42 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		7,901,209	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.674694	754,008	508,725 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.378464	495,860	187,665 54.00
60.00	06000	LABORATORY	0.131796	2,654,576	349,862 60.00
65.00	06500	RESPIRATORY THERAPY	0.138122	4,624,551	638,752 65.00
66.00	06600	PHYSICAL THERAPY	0.441448	1,460,974	644,944 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	0.176896	3,438,848	608,318 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205383	5,900,941	1,211,953 73.00
74.00	07400	RENAL DIALYSIS	0.383509	672,861	258,048 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	09850	OTHER REIMBURSABLE CC'S	0.000000	0	0 98.00
200.00		Total (sum of lines 50-94 and 96-98)		20,002,619	4,408,267 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		20,002,619	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet D-3 Date/Time Prepared: 1/13/2016 1:42 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		979,906	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.674694	104,906	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.378464	62,903	54.00
60.00	06000	LABORATORY	0.131067	318,287	60.00
65.00	06500	RESPIRATORY THERAPY	0.138077	595,029	65.00
66.00	06600	PHYSICAL THERAPY	0.441448	138,836	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.176896	376,856	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205383	1,147,293	73.00
74.00	07400	RENAL DIALYSIS	0.365408	83,143	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
98.00	09850	OTHER REIMBURSABLE CC'S	0.000000	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		2,827,253	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)		2,827,253	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet E Part B Date/Time Prepared: 1/13/2016 1:42 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		22,380	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 Wkst. D, Pt. IV, col. 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)		22,380	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		94,265	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		94,265	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		94,265	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		71,885	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)		22,380	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		18,853	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 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		3,527	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,527	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		3,527	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		3,527	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,527	40.00
40.01	Sequestration adjustment (see instructions)		71	40.01
41.00	Interim payments		1,207	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		2,249	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet E-1
Part I
Date/Time Prepared:
1/13/2016 1:42 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,830,160		1,207	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	11/25/2015	45,000		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	10/07/2015	375,000		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-330,000		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)		8,500,160		1,207	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		2,249	6.01
6.02	SETTLEMENT TO PROGRAM		6,824		0	6.02
7.00	Total Medicare program liability (see instructions)		8,493,336		3,456	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: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet E-3 Part IV Date/Time Prepared: 1/13/2016 1:42 pm
		Title XVII I	Hospital	PPS
				1.00
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)			8,013,150 1.00
2.00	Outlier Payments			1,097,104 2.00
3.00	Total PPS Payments (sum of lines 1 and 2)			9,110,254 3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)			0 4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)			0 5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)			0 6.00
7.00	Subtotal (see instructions)			9,110,254 7.00
8.00	Primary payer payments			0 8.00
9.00	Subtotal (line 7 less line 8).			9,110,254 9.00
10.00	Deductibles			21,200 10.00
11.00	Subtotal (line 9 minus line 10)			9,089,054 11.00
12.00	Coinsurance			740,277 12.00
13.00	Subtotal (line 11 minus line 12)			8,348,777 13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			489,065 14.00
15.00	Adjusted reimbursable bad debts (see instructions)			317,892 15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			438,001 16.00
17.00	Subtotal (sum of lines 13 and 15)			8,666,669 17.00
18.00	Direct graduate medical education payments (from Wkst. 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
21.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 21.50
21.99	Recovery of Accelerated Depreciation			0 21.99
22.00	Total amount payable to the provider (see instructions)			8,666,669 22.00
22.01	Sequestration adjustment (see instructions)			173,333 22.01
23.00	Interim payments			8,500,160 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)			-6,824 25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions)			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152007	Period: From 09/01/2014 To 08/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 1/13/2016 1:42 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		1,400,387		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)		1,400,387	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)		1,400,387	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		979,906		8.00
9.00	Ancillary service charges		2,827,253	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)		3,807,159	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)		3,807,159	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,406,772	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		1,400,387	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)		1,400,387	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)		1,400,387	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1,400,387	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)		1,400,387	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)		1,400,387	0	40.00
41.00	Interim payments		507,025		41.00
42.00	Balance due provider/program (line 40 minus line 41)		893,362	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet G

Date/Time Prepared:
1/13/2016 1:42 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-2,375	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	321,468	0	0	0	3.00
4.00	Accounts receivable	2,806,947	0	0	0	4.00
5.00	Other receivable	1,127	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-459,610	0	0	0	6.00
7.00	Inventory	178,593	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)	2,846,150	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	2,669,577	0	0	0	17.00
18.00	Accumulated depreciation	-2,494,955	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	4,138,342	0	0	0	23.00
24.00	Accumulated depreciation	-3,101,080	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	1,211,884	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	7,217	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,217	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	4,065,251	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,057,113	0	0	0	37.00
38.00	Salaries, wages, and fees payable	330,648	0	0	0	38.00
39.00	Payroll taxes payable	1,796	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	595,478	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,985,035	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	-18,883,365	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-18,883,365	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-16,898,330	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	20,963,581	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	20,963,581	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	4,065,251	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet G-1

Date/Time Prepared:
1/13/2016 1:42 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		23,158,361			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-2,194,785				2.00
3.00	Total (sum of line 1 and line 2)		20,963,576			0	3.00
4.00	Additions (credit adjustments)	0		0		0	4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	5		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)		5			0	10.00
11.00	Subtotal (line 3 plus line 10)		20,963,581			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)		20,963,581			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: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet G-2
Parts I & II
Date/Time Prepared:
1/13/2016 1:42 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	12,978,165		12,978,165	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)	12,978,165		12,978,165	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)	12,978,165		12,978,165	17.00
18.00	Ancillary services	34,478,955	0	34,478,955	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)	47,457,120	0	47,457,120	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		17,935,295		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)		17,935,295		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 152007

Period:
From 09/01/2014
To 08/31/2015

Worksheet G-3

Date/Time Prepared:
1/13/2016 1:42 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	47,457,120	1.00
2.00	Less contractual allowances and discounts on patients' accounts	31,746,568	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,710,552	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	17,935,295	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,224,743	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	1,313	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	16,804	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	538	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	97	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	11,206	24.00
25.00	Total other income (sum of lines 6-24)	29,958	25.00
26.00	Total (line 5 plus line 25)	-2,194,785	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)	-2,194,785	29.00