

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: 140306 Period: From 02/23/2011 To 08/31/2011 Worksheet S Parts I-III Date/Time Prepared: 2/27/2012 2:25 pm

**PART I - COST REPORT STATUS**

Provider use only 1.  Electronically filed cost report Date: 2/27/2012 Time: 2:25 pm  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only 5.  Cost Report Status 6. Date Received: 10. NPR Date:  
 (1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4  
 (2) Settled without Audit 8.  Initial Report for this Provider CCN 12.  If line 5, column 1 is 4: Enter  
 (3) Settled with Audit 9.  Final Report for this Provider CCN number of times reopened = 0-9.  
 (4) Reopened  
 (5) Amended

**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 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 Springfield for the cost reporting period beginning 02/23/2011 and ending 08/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement 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 identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	1,188,214	0	0	195,064	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
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
8.00 Nursing Facility	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	1,188,214	0	0	195,064	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet S-2 Part I Date/Time Prepared: 2/27/2012 2:24 pm
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		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 701 North Walnut Street	PO Box:		Zip Code: 62702		County: Sangamon			1.00	
2.00	City: Springfield	State: IL							2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	Kindred Hospital Springfield	140306	44100	1	02/23/2011	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF						N	N	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF						N	N	N	9.00
10.00	Hospital-Based NF						N		N	10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA						N	N	N	12.00
13.00	Separately Certified ASC						N	N	N	13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC						N	N	N	15.00
16.00	Hospital-Based Health Clinic - FQHC						N	N	N	16.00
17.00	Hospital-Based (CMHC) 1						N	N	N	17.00
17.10	Hospital-Based (CORF) 1						N	N	N	17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					02/23/2011	08/31/2011		20.00	
21.00	Type of Control (see instructions)					4				21.00
Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N		N		22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					2		N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0		25.00	
							1.00			
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 (1) for urban or (2) for rural.									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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet S-2 Part I Date/Time Prepared: 2/27/2012 2:24 pm		
		Beginning:	Ending:			
		1.00	2.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	Y	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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	
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

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		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1 the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000		65.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
				1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010									
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000		66.00	
		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. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000		67.00	
						1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)							0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)							0	76.00
						1.00			
80.00	Long Term Care Hospital PPS Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.						N		80.00

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				1.00	
<b>TEFRA Providers</b>					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.		N		86.00
			V	XIX	
			1.00	2.00	
<b>Title V or XIX Inpatient Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	2.00
<b>Miscellaneous Cost Reporting Information</b>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		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
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		100,000,000	100,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? 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? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00

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		1.00			2.00		
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		189003		140.00	
		1.00	2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: KINDRED HEALTHCARE INC	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00131		141.00	
142.00	Street: 680 SOUTH FOURTH AVENUE	PO Box:				142.00	
143.00	City: LOUISVILLE	State: KY		Zip Code: 40202		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			Y		145.00	
						1.00	
						2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A		Part B			
		1.00		2.00			
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		155.00	
156.00	Subprovider - IPF	N		N		156.00	
157.00	Subprovider - IRF	N		N		157.00	
158.00	Subprovider - Other	N		N		158.00	
159.00	SNF	N		N		159.00	
160.00	HHA	N		N		160.00	
161.00	CMHC	N		N		161.00	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5					0.00	
166.01						0.00	
166.02						0.00	
166.03						0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.			N		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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet S-2 Part II Date/Time Prepared: 2/27/2012 2:24 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	03/31/2012
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N	
			1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		Description	Y/N	Date
		0	1.00	2.00
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	01/31/2012	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		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		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		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		20.00

		Part A			
		Description	Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00 N	2.00	21.00
					1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		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.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		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		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
					Y/N
					Date
					1.00
					2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2011	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

		Part B		
		Y/N	Date	
		3.00	4.00	
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/31/2012	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		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		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		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		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	50	9,500	0.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						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)		50	9,500	0.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00		8.00
9.00 CORONARY CARE UNIT	32.00	0	0	0.00		9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00		10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00		11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00					13.00
14.00 Total (see instructions)		50	9,500	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	40.00	0	0			16.00
17.00 SUBPROVIDER - IRF	41.00	0	0			17.00
18.00 SUBPROVIDER	42.00	0	0			18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0			19.00
20.00 NURSING FACILITY	45.00	0	0			20.00
21.00 OTHER LONG TERM CARE	46.00	0	0			21.00
22.00 HOME HEALTH AGENCY	101.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00 HOSPICE	116.00	0	0			24.00
25.00 CMHC - CMHC	99.00					25.00
25.10 CMHC - CORF	99.10					25.10
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00 Total (sum of lines 14-26)		50				27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF	40.00					28.01
28.02 SUBPROVIDER - IRF	41.00					28.02
28.03 SUBPROVIDER	42.00					28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	466	41	656		1.00
2.00 HMO		13	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	466	41	656		7.00
8.00 INTENSIVE CARE UNIT	0	0	0	0		8.00
9.00 CORONARY CARE UNIT	0	0	0	0		9.00
10.00 BURN INTENSIVE CARE UNIT	0	0	0	0		10.00
11.00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0		11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	0		0	0		13.00
14.00 Total (see instructions)	0	466	41	656		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	0	0	0		16.00
17.00 SUBPROVIDER - IRF	0	0	0	0		17.00
18.00 SUBPROVIDER	0	0	0	0		18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0		19.00
20.00 NURSING FACILITY	0		0	0		20.00
21.00 OTHER LONG TERM CARE				0		21.00
22.00 HOME HEALTH AGENCY	0	0	0	0		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		0	0	0		24.00
25.00 CMHC - CMHC	0	0	0	0		25.00
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	0		28.00
28.01 SUBPROVIDER - IPF	0	0	0	0		28.01
28.02 SUBPROVIDER - IRF	0	0	0	0		28.02
28.03 SUBPROVIDER	0	0	0	0		28.03
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	17	1.00
2.00 HMO					1	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						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	43.40	0.00	0	17	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0.00	0.00	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00	0.00	0.00			19.00
20.00 NURSING FACILITY	0.00	0.00	0.00			20.00
21.00 OTHER LONG TERM CARE	0.00	0.00	0.00			21.00
22.00 HOME HEALTH AGENCY	0.00	0.00	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	0.00	0.00	0.00			23.00
24.00 HOSPICE	0.00	0.00	0.00			24.00
25.00 CMHC - CMHC	0.00	0.00	0.00			25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	43.40	0.00			27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF						28.01
28.02 SUBPROVIDER - IRF						28.02
28.03 SUBPROVIDER						28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	2	30		1.00
2.00 HMO				2.00
3.00 HMO IPF				3.00
4.00 HMO IRF				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)	2	30		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	0	0		16.00
17.00 SUBPROVIDER - IRF	0	0		17.00
18.00 SUBPROVIDER	0	0		18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE		0		21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
28.01 SUBPROVIDER - IPF				28.01
28.02 SUBPROVIDER - IRF				28.02
28.03 SUBPROVIDER				28.03
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet S-3  
Part II  
Date/Time Prepared:  
2/27/2012 2:24 pm

		Worksheet A Line Number	Amount Reported	Salary Adjustments for Vacation, Holiday, Sick, Other Paid Time Off, Severance, and Bonus, Paid to Employees and Not Reflected in Column 2	Recl assifi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	
		1.00	2.00	2.50	3.00	4.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	1,484,104	0	0	1,484,104	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0	3.00
4.00	Physician-Part A		0	0	0	0	4.00
4.01	Physicians - Part A - direct teaching		0	0	0	0	4.01
5.00	Physician-Part B		0	0	0	0	5.00
6.00	Non-physician-Part B		0	0	0	0	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0	7.00
7.01	Contracted interns and residents (in approved programs)		0	0	0	0	7.01
8.00	Home office personnel		0	0	0	0	8.00
9.00	SNF	44.00	0	0	0	0	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		144,833	0	0	144,833	11.00
12.00	Management and administrative services		0	0	0	0	12.00
13.00	Contract labor: physician-Part A		8,294	0	0	8,294	13.00
14.00	Home office salaries & wage-related costs		45,142	0	0	45,142	14.00
15.00	Home office: physician Part A		0	0	0	0	15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0	16.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		276,660	0	0	276,660	17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25		0	0	0	0	18.00
19.00	Excluded areas		0	0	0	0	19.00
20.00	Non-physician anesthetist Part A		0	0	0	0	20.00
21.00	Non-physician anesthetist Part B		0	0	0	0	21.00
22.00	Physician Part A		0	0	0	0	22.00
23.00	Physician Part B		0	0	0	0	23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0	0	24.00
25.00	Interns & residents (in an approved program)		0	0	0	0	25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits	4.00	0	0	0	0	26.00
27.00	Administrative & General	5.00	320,009	0	0	320,009	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0	29.00
30.00	Operation of Plant	7.00	59,620	0	0	59,620	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0	31.00
32.00	Housekeeping	9.00	0	0	0	0	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0	33.00
34.00	Dietary	10.00	0	0	0	0	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0	35.00
36.00	Cafeteria	11.00	0	0	0	0	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0	37.00
38.00	Nursing Administration	13.00	286,231	0	0	286,231	38.00
39.00	Central Services and Supply	14.00	42,656	0	0	42,656	39.00
40.00	Pharmacy	15.00	0	0	0	0	40.00
41.00	Medical Records & Medical Records Library	16.00	74,009	0	0	74,009	41.00
42.00	Social Service	17.00	50,173	0	0	50,173	42.00
43.00	Other General Service	18.00	0	0	0	0	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet S-3  
Part II  
Date/Time Prepared:  
2/27/2012 2:24 pm

		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		5.00	6.00	
<b>PART II - WAGE DATA</b>				
<b>SALARIES</b>				
1.00	Total salaries (see instructions)	45,170.00	32.86	1.00
2.00	Non-physician anesthetist Part A	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B	0.00	0.00	3.00
4.00	Physician-Part A	0.00	0.00	4.00
4.01	Physicians - Part A - direct teaching	0.00	0.00	4.01
5.00	Physician-Part B	0.00	0.00	5.00
6.00	Non-physician-Part B	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	0.00	0.00	7.00
7.01	Contracted interns and residents (in approved programs)	0.00	0.00	7.01
8.00	Home office personnel	0.00	0.00	8.00
9.00	SNF	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)	0.00	0.00	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>				
11.00	Contract labor (see instructions)	3,696.00	39.19	11.00
12.00	Management and administrative services	0.00	0.00	12.00
13.00	Contract labor: physician-Part A	40.00	207.35	13.00
14.00	Home office salaries & wage-related costs	926.00	48.75	14.00
15.00	Home office: physician Part A	0.00	0.00	15.00
16.00	Teaching physician salaries (see instructions)	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>				
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25			18.00
19.00	Excluded areas			19.00
20.00	Non-physician anesthetist Part A			20.00
21.00	Non-physician anesthetist Part B			21.00
22.00	Physician Part A			22.00
23.00	Physician Part B			23.00
24.00	Wage-related costs (RHC/FQHC)			24.00
25.00	Interns & residents (in an approved program)			25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>				
26.00	Employee Benefits	0.00	0.00	26.00
27.00	Administrative & General	6,571.00	48.70	27.00
28.00	Administrative & General under contract (see inst.)	0.00	0.00	28.00
29.00	Maintenance & Repairs	0.00	0.00	29.00
30.00	Operation of Plant	4,536.00	13.14	30.00
31.00	Laundry & Linen Service	0.00	0.00	31.00
32.00	Housekeeping	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)	0.00	0.00	33.00
34.00	Dietary	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)	0.00	0.00	35.00
36.00	Cafeteria	0.00	0.00	36.00
37.00	Maintenance of Personnel	0.00	0.00	37.00
38.00	Nursing Administration	7,718.00	37.09	38.00
39.00	Central Services and Supply	2,431.00	17.55	39.00
40.00	Pharmacy	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	3,134.00	23.61	41.00
42.00	Social Service	1,154.00	43.48	42.00
43.00	Other General Service	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet S-3  
Part III  
Date/Time Prepared:  
2/27/2012 2:24 pm

	Worksheet A Line Number	Amount Reported	Salary Adjustments for Vacation, Holiday, Sick, Other Paid Time Off, Severance, and Bonus, Paid to Employees and Not Reflected in Column 2	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	
	1.00	2.00	2.50	3.00	4.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>						
1.00	Net salaries (see instructions)	1,484,104	0	0	1,484,104	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0	2.00
3.00	Subtotal salaries (line 1 minus line 2)	1,484,104	0	0	1,484,104	3.00
4.00	Subtotal other wages & related costs (see inst.)	198,269	0	0	198,269	4.00
5.00	Subtotal wage-related costs (see inst.)	276,660	0	0	276,660	5.00
6.00	Total (sum of lines 3 thru 5)	1,959,033	0	0	1,959,033	6.00
7.00	Total overhead cost (see instructions)	832,698	0	0	832,698	7.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet S-3  
Part III  
Date/Time Prepared:  
2/27/2012 2:24 pm

		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>				
1.00	Net salaries (see instructions)	45,170.00	32.86	1.00
2.00	Excluded area salaries (see instructions)	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	45,170.00	32.86	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,662.00	42.53	4.00
5.00	Subtotal wage-related costs (see inst.)	0.00	18.64	5.00
6.00	Total (sum of lines 3 thru 5)	49,832.00	39.31	6.00
7.00	Total overhead cost (see instructions)	25,544.00	32.60	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2012 2:24 pm
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3.00
4.00	Prior Year Pension Service Cost	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	91,164	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	1,047	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)	476	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	67,204	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	100,407	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	12,329	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	4,033	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	276,660	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet S-3  
Part V  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	198,269	276,660	1.00
2.00	Hospital	198,269	276,660	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC	0	0	12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC	0	0	16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00		0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet S-10 Date/Time Prepared: 2/27/2012 2:24 pm
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			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		2.003000	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		25,426	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		220,490	6.00
7.00	Medicaid cost (line 1 times line 6)		441,641	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		416,215	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		416,215	19.00
			1.00	
			2.00	
			3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0
26.00	Total bad debt expense for the entire hospital complex (see instructions)			0
27.00	Medicare bad debts for the entire hospital complex (see instructions)			0
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			0
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			0
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			0
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		416,215	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 CAP REL COSTS-BLDG & FIXT		696,013	696,013	194,103	890,116	1.00
2.00 CAP REL COSTS-MVBLE EQUIP		309,889	309,889	26,282	336,171	2.00
3.00 OTHER CAP REL COSTS		220,385	220,385	-220,385	0	3.00
4.00 EMPLOYEE BENEFITS	0	282,587	282,587	0	282,587	4.00
5.00 ADMIN STRATIVE & GENERAL	320,009	447,891	767,900	0	767,900	5.00
7.00 OPERATION OF PLANT	59,620	310,977	370,597	0	370,597	7.00
8.00 LAUNDRY & LINEN SERVICE	0	7,593	7,593	0	7,593	8.00
9.00 HOUSEKEEPING	0	98,317	98,317	0	98,317	9.00
10.00 DIETARY	0	132,738	132,738	0	132,738	10.00
11.00 CAFETERIA	0	0	0	0	0	11.00
13.00 NURSING ADMINISTRATION	286,231	6,705	292,936	0	292,936	13.00
14.00 CENTRAL SERVICES & SUPPLY	42,656	6,505	49,161	0	49,161	14.00
15.00 PHARMACY	0	132,574	132,574	0	132,574	15.00
16.00 MEDICAL RECORDS & LIBRARY	74,009	5,649	79,658	0	79,658	16.00
17.00 SOCIAL SERVICE	50,173	10,743	60,916	0	60,916	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	423,655	58,708	482,363	-4,195	478,168	30.00
31.00 INTENSIVE CARE UNIT	0	-4,195	-4,195	4,195	0	31.00
32.00 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	0	43.00
44.00 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	2,925	2,925	0	2,925	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	39,176	-1,114	38,062	0	38,062	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	10,803	10,803	0	10,803	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	188,575	12,398	200,973	0	200,973	65.00
66.00 PHYSICAL THERAPY	0	22,055	22,055	0	22,055	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,487	17,487	0	17,487	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	69,995	69,995	0	69,995	73.00
74.00 RENAL DIALYSIS	0	1,253	1,253	0	1,253	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 PSYCHOLOGY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,484,104	2,858,881	4,342,985	0	4,342,985	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01 IDLE SPACE	0	0	0	0	0	194.01
194.02 REG HOSPITAL OFFICE	0	0	0	0	0	194.02
194.03 REG NURSING OFFICE	0	0	0	0	0	194.03
194.04 PHYSICIAN OFFICE	0	0	0	0	0	194.04
194.05 CORP DATA CENTER	0	0	0	0	0	194.05
194.06 DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07 OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08 REHABCARE NURSING	0	0	0	0	0	194.08
194.09 VISITOR MEALS	0	0	0	0	0	194.09
194.10 NONREIMBURSABLE PROJECTS	0	0	0	0	0	194.10
194.11 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00 TOTAL (SUM OF LINES 118-199)	1,484,104	2,858,881	4,342,985	0	4,342,985	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	CAP REL COSTS-BLDG & FIXT	24,005	914,121	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	706,593	1,042,764	2.00
3.00	OTHER CAP REL COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	0	282,587	4.00
5.00	ADMINISTRATIVE & GENERAL	418,824	1,186,724	5.00
7.00	OPERATION OF PLANT	-46	370,551	7.00
8.00	LAUNDRY & LINEN SERVICE	0	7,593	8.00
9.00	HOUSEKEEPING	93	98,410	9.00
10.00	DIETARY	-502	132,236	10.00
11.00	CAFETERIA	0	0	11.00
13.00	NURSING ADMINISTRATION	58	292,994	13.00
14.00	CENTRAL SERVICES & SUPPLY	326	49,487	14.00
15.00	PHARMACY	0	132,574	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	79,658	16.00
17.00	SOCIAL SERVICE	0	60,916	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	-6,538	471,630	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
45.00	NURSING FACILITY	0	0	45.00
46.00	OTHER LONG TERM CARE	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0	2,925	50.00
51.00	RECOVERY ROOM	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	7,118	45,180	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	RADIOISOTOPE	0	0	56.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	528	11,331	60.00
60.01	BLOOD LABORATORY	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	0	200,973	65.00
66.00	PHYSICAL THERAPY	-1,011	21,044	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,487	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	69,995	73.00
74.00	RENAL DIALYSIS	0	1,253	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	PSYCHOLOGY	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	CLINIC	0	0	90.00
91.00	EMERGENCY	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
94.00	HOME PROGRAM DIALYSIS	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
97.00	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
99.00	CMHC	0	0	99.00
99.10	CORF	0	0	99.10
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00	HOME HEALTH AGENCY	0	0	101.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6.00	7.00	
<b>SPECIAL PURPOSE COST CENTERS</b>			
105.00 KIDNEY ACQUISITION	0	0	105.00
106.00 HEART ACQUISITION	0	0	106.00
107.00 LIVER ACQUISITION	0	0	107.00
108.00 LUNG ACQUISITION	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	110.00
111.00 ISLET ACQUISITION	0	0	111.00
113.00 INTEREST EXPENSE	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
116.00 HOSPICE	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,149,448	5,492,433	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00 RESEARCH	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00 NONPAID WORKERS	0	0	193.00
194.00 NONALLOWABLE CASE MANAGER	0	0	194.00
194.01 IDLE SPACE	0	0	194.01
194.02 REG HOSPITAL OFFICE	0	0	194.02
194.03 REG NURSING OFFICE	0	0	194.03
194.04 PHYSICIAN OFFICE	0	0	194.04
194.05 CORP DATA CENTER	0	0	194.05
194.06 DATA CTR SUBLEASE (XODIAC)	0	0	194.06
194.07 OTHER NONREIMBURSABLE - OPEN	0	0	194.07
194.08 REHABCARE NURSING	0	0	194.08
194.09 VISITOR MEALS	0	0	194.09
194.10 NONREIMBURSABLE PROJECTS	0	0	194.10
194.11 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	194.11
200.00 TOTAL (SUM OF LINES 118-199)	1,149,448	5,492,433	200.00

RECLASSIFICATIONS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A-6

Date/Time Prepared:  
2/27/2012 2:24 pm

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
B - PREOPENING EXPENSE ACCOUNT CODING						
1.00	ADULTS & PEDIATRICS		30.00	0	4	1.00
	TOTALS			0	4	
C - RECLASS ICU EXPENSES TO ROUTINE						
1.00	INTENSIVE CARE UNIT		31.00	0	4,199	1.00
	TOTALS			0	4,199	
500.00	Grand Total: Increases			0	4,203	500.00

RECLASSIFICATIONS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A-6  
Date/Time Prepared:  
2/27/2012 2:24 pm

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
B - PREOPENING EXPENSE ACCOUNT CODING							
1.00	INTENSIVE CARE UNIT	31.00	0	4	0		1.00
	TOTALS		0	4			
C - RECLASS ICU EXPENSES TO ROUTINE							
1.00	ADULTS & PEDIATRICS	30.00	0	4,199	10		1.00
	TOTALS		0	4,199			
500.00	Grand Total: Decreases		0	4,203			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
2/27/2012 2:24 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	865,944	0	0	0	0	1.00
2.00	Land Improvements	0	10,963	0	10,963	0	2.00
3.00	Buildings and Fixtures	0	21,004,507	0	21,004,507	0	3.00
4.00	Building Improvements	0	3,179	0	3,179	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	2,963,232	0	2,963,232	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	865,944	23,981,881	0	23,981,881	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	865,944	23,981,881	0	23,981,881	0	10.00
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	CAP REL COSTS-BLDG & FIXT	695,263	750	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	289,898	19,991	0	0	0	2.00
3.00	Total (sum of lines 1-2)	985,161	20,741	0	0	0	3.00
<b>COMPUTATION OF RATIOS</b>					<b>ALLOCATION OF OTHER CAPITAL</b>		
Cost Center Description		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	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	21,884,593	0	21,884,593	0.880745	12,737	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,963,232	0	2,963,232	0.119255	1,725	2.00
3.00	Total (sum of lines 1-2)	24,847,825	0	24,847,825	1.000000	14,462	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
2/27/2012 2:24 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	865,944	0			1.00
2.00	Land Improvements	10,963	0			2.00
3.00	Buildings and Fixtures	21,004,507	0			3.00
4.00	Building Improvements	3,179	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	2,963,232	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	24,847,825	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	24,847,825	0			10.00
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	CAP REL COSTS-BLDG & FIXT	0	696,013			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	309,889			2.00
3.00	Total (sum of lines 1-2)	0	1,005,902			3.00
<b>ALLOCATION OF OTHER CAPITAL</b>						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT	181,366	0	194,103	721,799	750
2.00	CAP REL COSTS-MVBLE EQUIP	24,557	0	26,282	996,491	19,991
3.00	Total (sum of lines 1-2)	205,923	0	220,385	1,718,290	20,741

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	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	10,206	181,366	0	914,121	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,725	24,557	0	1,042,764	2.00
3.00	Total (sum of lines 1-2)	0	11,931	205,923	0	1,956,885	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A-8  
Date/Time Prepared:  
2/27/2012 2:24 pm

		Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
		Basis/Code (2)	Amount	Cost Center	Line #
		1.00	2.00	3.00	4.00
1.00	Investment income - buildings and fixtures (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - movable equipment (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00	Investment income - other (chapter 2)		0		0.00 3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-128	ADMINISTRATIVE & GENERAL	5.00 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-9,020	ADMINISTRATIVE & GENERAL	5.00 7.00
8.00	Television and radio service (chapter 21)	A	-46	OPERATION OF PLANT	7.00 8.00
9.00	Parking lot (chapter 21)		0		0.00 9.00
10.00	Provider-based physician adjustment	A-8-2	-6,010		10.00 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	270,832		12.00 12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests	B	-1,662	DIETARY	10.00 14.00
15.00	Rental of quarters to employee and others		0		0.00 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients		0		0.00 17.00
18.00	Sale of medical records and abstracts		0		0.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00	Vending machines	B	-546	DIETARY	10.00 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00 24.00
25.00	Utilization review - physicians' compensation (chapter 21)			UTILIZATION REVIEW-SNF	114.00 25.00
26.00	Depreciation - buildings and fixtures			OCAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - movable equipment			OCAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00 28.00
29.00	Physicians' assistant			0	0.00 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00 30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00			0		0.00 33.00
33.01	MISCELLANEOUS INCOME	B	-16	ADMINISTRATIVE & GENERAL	5.00 33.01
33.02			0		0.00 33.02
33.03			0		0.00 33.03
33.04			0		0.00 33.04
33.05	OCCUPATIONAL INCENTIVE INCOME	A	-11,039	ADMINISTRATIVE & GENERAL	5.00 33.05
33.06			0		0.00 33.06
33.07			0		0.00 33.07
33.08			0		0.00 33.08
33.09			0		0.00 33.09
33.10	OTHER MEDICARE NON ALLOWABLE	A	-4,009	ADMINISTRATIVE & GENERAL	5.00 33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	A	-65	ADMINISTRATIVE & GENERAL	5.00 33.11
33.12	OTHER OPERATING - PUBLIC RELATIONS	A	-7,500	ADMINISTRATIVE & GENERAL	5.00 33.12
33.13	OTHER OPERATING - MARKETING	A	-4,172	ADMINISTRATIVE & GENERAL	5.00 33.13
33.14			0		0.00 33.14
33.15			0		0.00 33.15
33.16			0		0.00 33.16
33.17			0		0.00 33.17
33.18			0		0.00 33.18
33.19			0		0.00 33.19
33.20	OTHER OPERATING - TRADE SHOW BOOTH	A	-52	ADMINISTRATIVE & GENERAL	5.00 33.20
33.21			0		0.00 33.21

ADJUSTMENTS TO EXPENSES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A-8

Date/Time Prepared:  
2/27/2012 2:24 pm

	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #		
			1.00	2.00	3.00	4.00
33.22		0		0.00	33.22	
33.23		0		0.00	33.23	
33.24		0		0.00	33.24	
33.25		0		0.00	33.25	
33.26		0		0.00	33.26	
33.27	MALPRACTICE FINITE COST	A	-726	ADMINISTRATIVE & GENERAL	5.00	33.27
33.28	AGGREGATE CAPITAL EROSION	A	-21,457	ADMINISTRATIVE & GENERAL	5.00	33.28
33.29	CABLE TV AND SATELLITE	A	-2,244	ADMINISTRATIVE & GENERAL	5.00	33.29
33.30			0		0.00	33.30
33.31			0		0.00	33.31
33.32			0		0.00	33.32
33.33			0		0.00	33.33
33.34	MALPRACTICE TAIL LIABILITY	A	-25,172	ADMINISTRATIVE & GENERAL	5.00	33.34
33.35	AGGREGATE CAP PYMT-NONALLOWABLE	A	1,323	ADMINISTRATIVE & GENERAL	5.00	33.35
33.36			0		0.00	33.36
33.37	MEDICARE VS BOOK BLDG	A	-3,109	CAP REL COSTS-BLDG & FIXT	1.00	33.37
33.38	MEDICARE VS BOOK MOV EQUIP	A	-55,944	CAP REL COSTS-MVBLE EQUIP	2.00	33.38
33.39	ASSET ADD-ON BLDG	A	29,645	CAP REL COSTS-BLDG & FIXT	1.00	33.39
33.40	ASSET ADD-ON MOV EQUIP	A	767,944	CAP REL COSTS-MVBLE EQUIP	2.00	33.40
33.41	OTHER OPERATING EXPENSE	A	-94	ADMINISTRATIVE & GENERAL	5.00	33.41
33.42			0		0.00	33.42
33.43	NON ALLOWABLE LOBBYING FEES	A	-2,295	ADMINISTRATIVE & GENERAL	5.00	33.43
33.44	BUSINESS INTERRUPTION INS PREMIUM	A	-2,531	CAP REL COSTS-BLDG & FIXT	1.00	33.44
33.45			0		0.00	33.45
33.46			0		0.00	33.46
33.47			0		0.00	33.47
33.48			0		0.00	33.48
33.49			0		0.00	33.49
33.50	PATIENT PHONE - DEPREC EQUIP	A	-5,407	CAP REL COSTS-MVBLE EQUIP	2.00	33.50
33.51	DEFERRED PRE OPENING COSTS	A	233,647	ADMINISTRATIVE & GENERAL	5.00	33.51
33.52			0		0.00	33.52
33.53			0		0.00	33.53
33.54			0		0.00	33.54
33.55			0		0.00	33.55
33.56			0		0.00	33.56
33.57			0		0.00	33.57
33.58			0		0.00	33.58
33.59			0		0.00	33.59
33.60			0		0.00	33.60
33.61			0		0.00	33.61
33.62			0		0.00	33.62
33.63			0		0.00	33.63
33.64			0		0.00	33.64
33.65			0		0.00	33.65
33.66			0		0.00	33.66
33.67			0		0.00	33.67
33.68			0		0.00	33.68
33.69			0		0.00	33.69
33.70	PHYSICIAN FEE ADJUSTMENT	A	-2,005	ADULTS & PEDIATRICS	30.00	33.70
33.71			0		0.00	33.71
33.72			0		0.00	33.72
33.73			0		0.00	33.73
33.74			0		0.00	33.74
33.75	PHYSICIAN FEE ADJUSTMENT	A	765	LABORATORY	60.00	33.75
33.76	PHYSICIAN FEE ADJUSTMENT	A	1,240	RESPIRATORY THERAPY	65.00	33.76
33.77			0		0.00	33.77
33.78			0		0.00	33.78
33.79			0		0.00	33.79
33.80			0		0.00	33.80
33.81			0		0.00	33.81
33.82			0		0.00	33.82
33.83	CORRECT JANUARY 2011 ACCRUALS	A	93	HOUSEKEEPING	9.00	33.83
33.84	CORRECT JANUARY 2011 ACCRUALS	A	1,706	DIETARY	10.00	33.84
33.85	CORRECT JANUARY 2011 ACCRUALS	A	58	NURSING ADMINISTRATION	13.00	33.85
33.86	CORRECT JANUARY 2011 ACCRUALS	A	326	CENTRAL SERVICES & SUPPLY	14.00	33.86
33.87	CORRECT JANUARY 2011 ACCRUALS	A	4,908	RADIOLOGY-DIAGNOSTIC	54.00	33.87
33.88	CORRECT JANUARY 2011 ACCRUALS	A	2,210	RADIOLOGY-DIAGNOSTIC	54.00	33.88
33.89			0		0.00	33.89

ADJUSTMENTS TO EXPENSES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A-8

Date/Time Prepared:  
2/27/2012 2:24 pm

		Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
		Basis/Code (2)	Amount	Cost Center	Line #
		1.00	2.00	3.00	4.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,149,448		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A-8  
Date/Time Prepared:  
2/27/2012 2:24 pm

		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	9	1.00
2.00	Investment income - movable equipment (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - buildings and fixtures	0	26.00
27.00	Depreciation - movable equipment	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00		0	33.00
33.01	MISCELLANEOUS INCOME	0	33.01
33.02		0	33.02
33.03		0	33.03
33.04		0	33.04
33.05	OCCUPATIONAL INCENTIVE INCOME	0	33.05
33.06		0	33.06
33.07		0	33.07
33.08		0	33.08
33.09		0	33.09
33.10	OTHER MEDICARE NON ALLOWABLE	0	33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	0	33.11
33.12	OTHER OPERATING - PUBLIC RELATIONS	0	33.12
33.13	OTHER OPERATING - MARKETING	0	33.13
33.14		0	33.14
33.15		0	33.15
33.16		0	33.16
33.17		0	33.17
33.18		0	33.18
33.19		0	33.19
33.20	OTHER OPERATING - TRADE SHOW BOOTH	0	33.20
33.21		0	33.21
33.22		0	33.22
33.23		0	33.23
33.24		0	33.24
33.25		0	33.25
33.26		0	33.26
33.27	MALPRACTICE FINITE COST	0	33.27

ADJUSTMENTS TO EXPENSES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A-8

Date/Time Prepared:  
2/27/2012 2:24 pm

		Wkst. A-7 Ref.	
		5.00	
33.28	AGGREGATE CAPITAL EROSION	0	33.28
33.29	CABLE TV AND SATELLITE	0	33.29
33.30		0	33.30
33.31		0	33.31
33.32		0	33.32
33.33		0	33.33
33.34	MALPRACTICE TAIL LIABILITY	0	33.34
33.35	AGGREGATE CAP PYMT-NONALLOWABLE	0	33.35
33.36		0	33.36
33.37	MEDICARE VS BOOK BLDG	9	33.37
33.38	MEDICARE VS BOOK MOV EQUIP	9	33.38
33.39	ASSET ADD-ON BLDG	9	33.39
33.40	ASSET ADD-ON MOV EQUIP	9	33.40
33.41	OTHER OPERATING EXPENSE	0	33.41
33.42		0	33.42
33.43	NON ALLOWABLE LOBBYING FEES	0	33.43
33.44	BUSINESS INTERRUPTION INS PREMIUM	12	33.44
33.45		0	33.45
33.46		0	33.46
33.47		0	33.47
33.48		0	33.48
33.49		0	33.49
33.50	PATIENT PHONE - DEPREC EQUIP	9	33.50
33.51	DEFERRED PRE OPENING COSTS	0	33.51
33.52		0	33.52
33.53		0	33.53
33.54		0	33.54
33.55		0	33.55
33.56		0	33.56
33.57		0	33.57
33.58		0	33.58
33.59		0	33.59
33.60		0	33.60
33.61		0	33.61
33.62		0	33.62
33.63		0	33.63
33.64		0	33.64
33.65		0	33.65
33.66		0	33.66
33.67		0	33.67
33.68		0	33.68
33.69		0	33.69
33.70	PHYSICIAN FEE ADJUSTMENT	0	33.70
33.71		0	33.71
33.72		0	33.72
33.73		0	33.73
33.74		0	33.74
33.75	PHYSICIAN FEE ADJUSTMENT	0	33.75
33.76	PHYSICIAN FEE ADJUSTMENT	0	33.76
33.77		0	33.77
33.78		0	33.78
33.79		0	33.79
33.80		0	33.80
33.81		0	33.81
33.82		0	33.82
33.83	CORRECT JANUARY 2011 ACCRUALS	0	33.83
33.84	CORRECT JANUARY 2011 ACCRUALS	0	33.84
33.85	CORRECT JANUARY 2011 ACCRUALS	0	33.85
33.86	CORRECT JANUARY 2011 ACCRUALS	0	33.86
33.87	CORRECT JANUARY 2011 ACCRUALS	0	33.87
33.88	CORRECT JANUARY 2011 ACCRUALS	0	33.88
33.89		0	33.89
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A-8-1

Date/Time Prepared:  
2/27/2012 2:24 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	1.00
2.00	4.00	EMPLOYEE BENEFITS	Workers Comp Premium	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	3.00
4.00	16.00	MEDICAL RECORDS & LIBRARY	Hospital Related services	4.00
4.01	0.00			4.01
4.02	66.00	PHYSICAL THERAPY	Therapy Services	4.02
4.03	0.00			4.03
4.04	0.00			4.04
4.05	0.00			4.05
4.06	0.00			4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			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	
	1.00	2.00	3.00	
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>				

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

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

6.00	B	KINDRED INC-HOS	100.00	6.00
7.00	B	KINDRED INC-HOS	100.00	7.00
8.00	B	KINDRED INC-HOS	100.00	8.00
9.00	B	KINDRED INC-HOS	100.00	9.00
10.00			0.00	10.00
10.01	B	KINDRED INC-HOS	100.00	10.01
10.02			0.00	10.02
10.03			0.00	10.03
10.04			0.00	10.04
10.05			0.00	10.05
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: 140306

Period: From 02/23/2011 To 08/31/2011

Worksheet A-8-1

Date/Time Prepared: 2/27/2012 2:24 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>						
1.00	348,161	76,318	271,843	0		1.00
2.00	59,567	59,567	0	0		2.00
3.00	111,643	111,643	0	0		3.00
4.00	214	214	0	0		4.00
4.01	0	0	0	0		4.01
4.02	20,299	21,310	-1,011	0		4.02
4.03	0	0	0	0		4.03
4.04	0	0	0	0		4.04
4.05	0	0	0	0		4.05
4.06	0	0	0	0		4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	539,884	269,052	270,832		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			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	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	Admin & Gen	100.00	HomeOffice Cost	6.00
7.00	Cornerstone	100.00	Worker Comp Ins	7.00
8.00	Cornerstone	100.00	Liability Insur	8.00
9.00	KH-Lou/Phoenix	100.00	Transcript Svcs	9.00
10.00		0.00		10.00
10.01	People First	100.00	Therapy Svcs	10.01
10.02		0.00		10.02
10.03		0.00		10.03
10.04		0.00		10.04
10.05		0.00		10.05
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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A-8-2

Date/Time Prepared:  
2/27/2012 2:24 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	0.00	Dr. A	0	0	1.00
2.00	65.00	Dr. B	1,240	1,240	2.00
3.00	30.00	Dr. C	0	0	3.00
4.00	30.00	Dr. D	4,935	0	4.00
5.00	30.00	Dr. E	413	0	5.00
6.00	60.00	Dr. F	765	0	6.00
7.00	30.00	Dr. G	1,821	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (Lines 1.00 through 199.00)	9,174	1,240	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A-8-2

Date/Time Prepared:  
2/27/2012 2:24 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	171,400	0	0	0	2.00
3.00	0	171,400	0	0	0	3.00
4.00	4,935	171,400	21	1,730	87	4.00
5.00	413	171,400	3	247	12	5.00
6.00	765	219,500	5	528	26	6.00
7.00	1,821	171,400	8	659	33	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	7,934		37	3,164	158	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A-8-2

Date/Time Prepared:  
2/27/2012 2:24 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	1,730	4.00
5.00	0	0	0	0	247	5.00
6.00	0	0	0	0	528	6.00
7.00	0	0	0	0	659	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	3,164	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet A-8-2

Date/Time Prepared:  
2/27/2012 2:24 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	0	1.00
2.00	0	1,240	2.00
3.00	0	0	3.00
4.00	3,205	3,205	4.00
5.00	166	166	5.00
6.00	237	237	6.00
7.00	1,162	1,162	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	4,770	6,010	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 CAP REL COSTS-BLDG & FIXT	914,121	914,121				1.00
2.00 CAP REL COSTS-MVBLE EQUIP	1,042,764		1,042,764			2.00
4.00 EMPLOYEE BENEFITS	282,587	3,368	3,842	289,797		4.00
5.00 ADMINISTRATIVE & GENERAL	1,186,724	80,650	92,000	62,487	1,421,861	5.00
7.00 OPERATION OF PLANT	370,551	167,745	191,352	11,642	741,290	7.00
8.00 LAUNDRY & LINEN SERVICE	7,593	20,351	23,215	0	51,159	8.00
9.00 HOUSEKEEPING	98,410	15,155	17,287	0	130,852	9.00
10.00 DIETARY	132,236	47,583	54,279	0	234,098	10.00
11.00 CAFETERIA	0	43,489	49,610	0	93,099	11.00
13.00 NURSING ADMINISTRATION	292,994	6,387	7,286	55,891	362,558	13.00
14.00 CENTRAL SERVICES & SUPPLY	49,487	57,947	66,102	8,329	181,865	14.00
15.00 PHARMACY	132,574	28,596	32,621	0	193,791	15.00
16.00 MEDICAL RECORDS & LIBRARY	79,658	10,539	12,022	14,452	116,671	16.00
17.00 SOCIAL SERVICE	60,916	7,055	8,048	9,797	85,816	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	471,630	359,557	410,156	82,727	1,324,070	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	0	43.00
44.00 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	2,925	0	0	0	2,925	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	45,180	5,864	6,690	7,650	65,384	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	11,331	2,526	2,881	0	16,738	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	200,973	12,687	14,472	36,822	264,954	65.00
66.00 PHYSICAL THERAPY	21,044	25,722	29,342	0	76,108	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	17,487	0	0	0	17,487	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	69,995	0	0	0	69,995	73.00
74.00 RENAL DIALYSIS	1,253	18,900	21,559	0	41,712	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 PSYCHOLOGY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5,492,433	914,121	1,042,764	289,797	5,492,433	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01 IDLE SPACE	0	0	0	0	0	194.01
194.02 REG HOSPITAL OFFICE	0	0	0	0	0	194.02
194.03 REG NURSING OFFICE	0	0	0	0	0	194.03
194.04 PHYSICIAN OFFICE	0	0	0	0	0	194.04
194.05 CORP DATA CENTER	0	0	0	0	0	194.05
194.06 DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07 OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08 REHABCARE NURSING	0	0	0	0	0	194.08
194.09 VISITOR MEALS	0	0	0	0	0	194.09
194.10 NONREIMBURSABLE PROJECTS	0	0	0	0	0	194.10
194.11 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	201.00
202.00 TOTAL (sum lines 118-201)	5,492,433	914,121	1,042,764	289,797	5,492,433	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet B Part I Date/Time Prepared: 2/27/2012 2:24 pm
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Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL	1,421,861				5.00
7.00	OPERATION OF PLANT	258,935	1,000,225			7.00
8.00	LAUNDRY & LINEN SERVICE	17,870	30,732	99,761		8.00
9.00	HOUSEKEEPING	45,707	22,885	0	199,444	9.00
10.00	DIETARY	81,771	71,855	0	15,139	402,863
11.00	CAFETERIA	32,520	65,673	0	13,837	0
13.00	NURSING ADMINISTRATION	126,643	9,645	0	2,032	0
14.00	CENTRAL SERVICES & SUPPLY	63,526	87,506	0	18,437	0
15.00	PHARMACY	67,692	43,183	0	9,098	0
16.00	MEDICAL RECORDS & LIBRARY	40,754	15,914	0	3,353	0
17.00	SOCIAL SERVICE	29,976	10,653	0	2,245	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	462,498	542,968	99,761	114,399	402,863
31.00	INTENSIVE CARE UNIT	0	0	0	0	0
32.00	CORONARY CARE UNIT	0	0	0	0	0
33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
40.00	SUBPROVIDER - I/PF	0	0	0	0	0
41.00	SUBPROVIDER - I/RF	0	0	0	0	0
42.00	SUBPROVIDER	0	0	0	0	0
43.00	NURSERY	0	0	0	0	0
44.00	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	NURSING FACILITY	0	0	0	0	0
46.00	OTHER LONG TERM CARE	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	1,022	0	0	0	0
51.00	RECOVERY ROOM	0	0	0	0	0
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	ANESTHESIOLOGY	0	0	0	0	0
54.00	RADIOLOGY-DIAGNOSTIC	22,839	8,856	0	1,866	0
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	RADIOISOTOPE	0	0	0	0	0
57.00	CT SCAN	0	0	0	0	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	LABORATORY	5,847	3,814	0	804	0
60.01	BLOOD LABORATORY	0	0	0	0	0
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	RESPIRATORY THERAPY	92,549	19,158	0	4,037	0
66.00	PHYSICAL THERAPY	26,585	38,843	0	8,184	0
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	SPEECH PATHOLOGY	0	0	0	0	0
69.00	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,108	0	0	0	0
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	24,449	0	0	0	0
74.00	RENAL DIALYSIS	14,570	28,540	0	6,013	0
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0
76.00	PSYCHOLOGY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	CLINIC	0	0	0	0	0
91.00	EMERGENCY	0	0	0	0	0
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0
95.00	AMBULANCE SERVICES	0	0	0	0	0
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
97.00	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
99.00	CMHC	0	0	0	0	0
99.10	CORF	0	0	0	0	0
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00	HOME HEALTH AGENCY	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

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Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	5.00	7.00	8.00	9.00	10.00	
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,421,861	1,000,225	99,761	199,444	402,863	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01 IDLE SPACE	0	0	0	0	0	194.01
194.02 REG HOSPITAL OFFICE	0	0	0	0	0	194.02
194.03 REG NURSING OFFICE	0	0	0	0	0	194.03
194.04 PHYSICIAN OFFICE	0	0	0	0	0	194.04
194.05 CORP DATA CENTER	0	0	0	0	0	194.05
194.06 DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07 OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08 REHABCARE NURSING	0	0	0	0	0	194.08
194.09 VISITOR MEALS	0	0	0	0	0	194.09
194.10 NONREIMBURSABLE PROJECTS	0	0	0	0	0	194.10
194.11 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	1,421,861	1,000,225	99,761	199,444	402,863	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140306

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To 08/31/2011

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Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	205,129					11.00
13.00 NURSING ADMINISTRATION	44,872	545,750				13.00
14.00 CENTRAL SERVICES & SUPPLY	12,821	0	364,155			14.00
15.00 PHARMACY	0	0	23,329	337,093		15.00
16.00 MEDICAL RECORDS & LIBRARY	19,231	0	1,214	0	197,137	16.00
17.00 SOCIAL SERVICE	6,410	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	76,923	545,750	141,989	5,262	67,000	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	0	43.00
44.00 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	0	4,187	0	1,008	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	6,410	0	20,717	0	2,011	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	5,889	0	13,650	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	38,462	0	63,255	0	20,239	65.00
66.00 PHYSICAL THERAPY	0	0	4,098	0	5,722	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	96,971	0	15,045	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	331,831	72,462	73.00
74.00 RENAL DIALYSIS	0	0	2,506	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 PSYCHOLOGY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140306

Period:  
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Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	205,129	545,750	364,155	337,093	197,137	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01 IDLE SPACE	0	0	0	0	0	194.01
194.02 REG HOSPITAL OFFICE	0	0	0	0	0	194.02
194.03 REG NURSING OFFICE	0	0	0	0	0	194.03
194.04 PHYSICIAN OFFICE	0	0	0	0	0	194.04
194.05 CORP DATA CENTER	0	0	0	0	0	194.05
194.06 DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07 OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08 REHABCARE NURSING	0	0	0	0	0	194.08
194.09 VISITOR MEALS	0	0	0	0	0	194.09
194.10 NONREIMBURSABLE PROJECTS	0	0	0	0	0	194.10
194.11 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)	205,129	545,750	364,155	337,093	197,137	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140306

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To 08/31/2011

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Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	17.00	24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
13.00 NURSING ADMINISTRATION						13.00
14.00 CENTRAL SERVICES & SUPPLY						14.00
15.00 PHARMACY						15.00
16.00 MEDICAL RECORDS & LIBRARY						16.00
17.00 SOCIAL SERVICE	135,100					17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	135,100	3,918,583	0	3,918,583		30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0		31.00
32.00 CORONARY CARE UNIT	0	0	0	0		32.00
33.00 BURN INTENSIVE CARE UNIT	0	0	0	0		33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0		34.00
40.00 SUBPROVIDER - I/PF	0	0	0	0		40.00
41.00 SUBPROVIDER - I/RF	0	0	0	0		41.00
42.00 SUBPROVIDER	0	0	0	0		42.00
43.00 NURSERY	0	0	0	0		43.00
44.00 SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00 NURSING FACILITY	0	0	0	0		45.00
46.00 OTHER LONG TERM CARE	0	0	0	0		46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	9,142	0	9,142		50.00
51.00 RECOVERY ROOM	0	0	0	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00 ANESTHESIOLOGY	0	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	128,083	0	128,083		54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0		55.00
56.00 RADIOISOTOPE	0	0	0	0		56.00
57.00 CT SCAN	0	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00 LABORATORY	0	46,742	0	46,742		60.00
60.01 BLOOD LABORATORY	0	0	0	0		60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0		61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0	502,654	0	502,654		65.00
66.00 PHYSICAL THERAPY	0	159,540	0	159,540		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	135,611	0	135,611		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	498,737	0	498,737		73.00
74.00 RENAL DIALYSIS	0	93,341	0	93,341		74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0		75.00
76.00 PSYCHOLOGY	0	0	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00 CLINIC	0	0	0	0		90.00
91.00 EMERGENCY	0	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0		94.00
95.00 AMBULANCE SERVICES	0	0	0	0		95.00
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
97.00 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0		97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
99.00 CMHC	0	0	0	0		99.00
99.10 CORF	0	0	0	0		99.10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	24.00	25.00	26.00	
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
105.00 KIDNEY ACQUISITION	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	135,100	5,492,433	0	5,492,433	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	193.00
194.00 NONALLOWABLE CASE MANAGER	0	0	0	0	194.00
194.01 IDLE SPACE	0	0	0	0	194.01
194.02 REG HOSPITAL OFFICE	0	0	0	0	194.02
194.03 REG NURSING OFFICE	0	0	0	0	194.03
194.04 PHYSICIAN OFFICE	0	0	0	0	194.04
194.05 CORP DATA CENTER	0	0	0	0	194.05
194.06 DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07 OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.07
194.08 REHABCARE NURSING	0	0	0	0	194.08
194.09 VISITOR MEALS	0	0	0	0	194.09
194.10 NONREIMBURSABLE PROJECTS	0	0	0	0	194.10
194.11 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)	135,100	5,492,433	0	5,492,433	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	3,368	3,842	7,210	7,210
5.00	ADMINISTRATIVE & GENERAL	41,064	80,650	92,000	213,714	1,555
7.00	OPERATION OF PLANT	0	167,745	191,352	359,097	290
8.00	LAUNDRY & LINEN SERVICE	0	20,351	23,215	43,566	0
9.00	HOUSEKEEPING	0	15,155	17,287	32,442	0
10.00	DIETARY	0	47,583	54,279	101,862	0
11.00	CAFETERIA	0	43,489	49,610	93,099	0
13.00	NURSING ADMINISTRATION	0	6,387	7,286	13,673	1,391
14.00	CENTRAL SERVICES & SUPPLY	0	57,947	66,102	124,049	207
15.00	PHARMACY	0	28,596	32,621	61,217	0
16.00	MEDICAL RECORDS & LIBRARY	0	10,539	12,022	22,561	360
17.00	SOCIAL SERVICE	0	7,055	8,048	15,103	244
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	0	359,557	410,156	769,713	2,057
31.00	INTENSIVE CARE UNIT	0	0	0	0	0
32.00	CORONARY CARE UNIT	0	0	0	0	0
33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
40.00	SUBPROVIDER - IPF	0	0	0	0	0
41.00	SUBPROVIDER - IRF	0	0	0	0	0
42.00	SUBPROVIDER	0	0	0	0	0
43.00	NURSERY	0	0	0	0	0
44.00	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	NURSING FACILITY	0	0	0	0	0
46.00	OTHER LONG TERM CARE	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0	0	0	0	0
51.00	RECOVERY ROOM	0	0	0	0	0
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	ANESTHESIOLOGY	0	0	0	0	0
54.00	RADIOLOGY-DIAGNOSTIC	0	5,864	6,690	12,554	190
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	RADIOISOTOPE	0	0	0	0	0
57.00	CT SCAN	0	0	0	0	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	LABORATORY	0	2,526	2,881	5,407	0
60.01	BLOOD LABORATORY	0	0	0	0	0
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	RESPIRATORY THERAPY	0	12,687	14,472	27,159	916
66.00	PHYSICAL THERAPY	0	25,722	29,342	55,064	0
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	SPEECH PATHOLOGY	0	0	0	0	0
69.00	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	RENAL DIALYSIS	0	18,900	21,559	40,459	0
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0
76.00	PSYCHOLOGY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	CLINIC	0	0	0	0	0
91.00	EMERGENCY	0	0	0	0	0
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0
95.00	AMBULANCE SERVICES	0	0	0	0	0
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
97.00	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
99.00	CMHC	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
99.10 CORF	0	0	0	0	0	99.10
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	41,064	914,121	1,042,764	1,997,949	7,210	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01 IDLE SPACE	0	0	0	0	0	194.01
194.02 REG HOSPITAL OFFICE	0	0	0	0	0	194.02
194.03 REG NURSING OFFICE	0	0	0	0	0	194.03
194.04 PHYSICIAN OFFICE	0	0	0	0	0	194.04
194.05 CORP DATA CENTER	0	0	0	0	0	194.05
194.06 DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07 OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08 REHABCARE NURSING	0	0	0	0	0	194.08
194.09 VISITOR MEALS	0	0	0	0	0	194.09
194.10 NONREIMBURSABLE PROJECTS	0	0	0	0	0	194.10
194.11 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		201.00
202.00 TOTAL (sum lines 118-201)	41,064	914,121	1,042,764	1,997,949	7,210	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
	5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	EMPLOYEE BENEFITS					4.00	
5.00	ADMINISTRATIVE & GENERAL	215,269				5.00	
7.00	OPERATION OF PLANT	39,202	398,589			7.00	
8.00	LAUNDRY & LINEN SERVICE	2,705	12,247	58,518		8.00	
9.00	HOUSEKEEPING	6,920	9,120	0	48,482	9.00	
10.00	DIETARY	12,380	28,634	0	3,680	146,556	10.00
11.00	CAFETERIA	4,923	26,171	0	3,364	0	11.00
13.00	NURSING ADMINISTRATION	19,174	3,844	0	494	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	9,618	34,871	0	4,482	0	14.00
15.00	PHARMACY	10,248	17,208	0	2,212	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	6,170	6,342	0	815	0	16.00
17.00	SOCIAL SERVICE	4,538	4,245	0	546	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	70,023	216,371	58,518	27,808	146,556	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - I/RF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	155	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,458	3,529	0	454	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	885	1,520	0	195	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	14,012	7,635	0	981	0	65.00
66.00	PHYSICAL THERAPY	4,025	15,479	0	1,989	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	925	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,702	0	0	0	0	73.00
74.00	RENAL DIALYSIS	2,206	11,373	0	1,462	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	PSYCHOLOGY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	5.00	7.00	8.00	9.00	10.00	
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	215,269	398,589	58,518	48,482	146,556	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01 IDLE SPACE	0	0	0	0	0	194.01
194.02 REG HOSPITAL OFFICE	0	0	0	0	0	194.02
194.03 REG NURSING OFFICE	0	0	0	0	0	194.03
194.04 PHYSICIAN OFFICE	0	0	0	0	0	194.04
194.05 CORP DATA CENTER	0	0	0	0	0	194.05
194.06 DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07 OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08 REHABCARE NURSING	0	0	0	0	0	194.08
194.09 VISITOR MEALS	0	0	0	0	0	194.09
194.10 NONREIMBURSABLE PROJECTS	0	0	0	0	0	194.10
194.11 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)	215,269	398,589	58,518	48,482	146,556	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00						1.00
2.00						2.00
4.00						4.00
5.00						5.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00	127,557					11.00
13.00	27,903	66,479				13.00
14.00	7,972	0	181,199			14.00
15.00	0	0	11,608	102,493		15.00
16.00	11,958	0	604	0	48,810	16.00
17.00	3,986	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	47,835	66,479	70,653	1,600	16,588	30.00
31.00	0	0	0	0	0	31.00
32.00	0	0	0	0	0	32.00
33.00	0	0	0	0	0	33.00
34.00	0	0	0	0	0	34.00
40.00	0	0	0	0	0	40.00
41.00	0	0	0	0	0	41.00
42.00	0	0	0	0	0	42.00
43.00	0	0	0	0	0	43.00
44.00	0	0	0	0	0	44.00
45.00	0	0	0	0	0	45.00
46.00	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	0	0	2,083	0	250	50.00
51.00	0	0	0	0	0	51.00
52.00	0	0	0	0	0	52.00
53.00	0	0	0	0	0	53.00
54.00	3,986	0	10,309	0	498	54.00
55.00	0	0	0	0	0	55.00
56.00	0	0	0	0	0	56.00
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	0	0	2,930	0	3,380	60.00
60.01	0	0	0	0	0	60.01
61.00	0	0	0	0	0	61.00
62.00	0	0	0	0	0	62.00
63.00	0	0	0	0	0	63.00
64.00	0	0	0	0	0	64.00
65.00	23,917	0	31,475	0	5,011	65.00
66.00	0	0	2,039	0	1,417	66.00
67.00	0	0	0	0	0	67.00
68.00	0	0	0	0	0	68.00
69.00	0	0	0	0	0	69.00
70.00	0	0	0	0	0	70.00
71.00	0	0	48,251	0	3,725	71.00
72.00	0	0	0	0	0	72.00
73.00	0	0	0	100,893	17,941	73.00
74.00	0	0	1,247	0	0	74.00
75.00	0	0	0	0	0	75.00
76.00	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	0	0	0	0	0	88.00
89.00	0	0	0	0	0	89.00
90.00	0	0	0	0	0	90.00
91.00	0	0	0	0	0	91.00
92.00	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00	0	0	0	0	0	94.00
95.00	0	0	0	0	0	95.00
96.00	0	0	0	0	0	96.00
97.00	0	0	0	0	0	97.00
98.00	0	0	0	0	0	98.00
99.00	0	0	0	0	0	99.00
99.10	0	0	0	0	0	99.10
100.00	0	0	0	0	0	100.00
101.00	0	0	0	0	0	101.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	127,557	66,479	181,199	102,493	48,810	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01 IDLE SPACE	0	0	0	0	0	194.01
194.02 REG HOSPITAL OFFICE	0	0	0	0	0	194.02
194.03 REG NURSING OFFICE	0	0	0	0	0	194.03
194.04 PHYSICIAN OFFICE	0	0	0	0	0	194.04
194.05 CORP DATA CENTER	0	0	0	0	0	194.05
194.06 DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07 OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08 REHABCARE NURSING	0	0	0	0	0	194.08
194.09 VISITOR MEALS	0	0	0	0	0	194.09
194.10 NONREIMBURSABLE PROJECTS	0	0	0	0	0	194.10
194.11 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)	127,557	66,479	181,199	102,493	48,810	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 CAP REL COSTS-BLDG & FIXT					1.00
2.00 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.00 ADMINISTRATIVE & GENERAL					5.00
7.00 OPERATION OF PLANT					7.00
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
13.00 NURSING ADMINISTRATION					13.00
14.00 CENTRAL SERVICES & SUPPLY					14.00
15.00 PHARMACY					15.00
16.00 MEDICAL RECORDS & LIBRARY					16.00
17.00 SOCIAL SERVICE	28,662				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 ADULTS & PEDIATRICS	28,662	1,522,863	0	1,522,863	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00 CORONARY CARE UNIT	0	0	0	0	32.00
33.00 BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00 SUBPROVIDER - I PF	0	0	0	0	40.00
41.00 SUBPROVIDER - I RF	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	43.00
44.00 SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 NURSING FACILITY	0	0	0	0	45.00
46.00 OTHER LONG TERM CARE	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	0	2,488	0	2,488	50.00
51.00 RECOVERY ROOM	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	34,978	0	34,978	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 LABORATORY	0	14,317	0	14,317	60.00
60.01 BLOOD LABORATORY	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	111,106	0	111,106	65.00
66.00 PHYSICAL THERAPY	0	80,013	0	80,013	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	52,901	0	52,901	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	122,536	0	122,536	73.00
74.00 RENAL DIALYSIS	0	56,747	0	56,747	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00 PSYCHOLOGY	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	95.00
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
97.00 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
99.00 CMHC	0	0	0	0	99.00
99.10 CORF	0	0	0	0	99.10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	24.00	25.00	26.00	
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
105.00 KIDNEY ACQUISITION	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	28,662	1,997,949	0	1,997,949	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	193.00
194.00 NONALLOWABLE CASE MANAGER	0	0	0	0	194.00
194.01 IDLE SPACE	0	0	0	0	194.01
194.02 REG HOSPITAL OFFICE	0	0	0	0	194.02
194.03 REG NURSING OFFICE	0	0	0	0	194.03
194.04 PHYSICIAN OFFICE	0	0	0	0	194.04
194.05 CORP DATA CENTER	0	0	0	0	194.05
194.06 DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07 OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.07
194.08 REHABCARE NURSING	0	0	0	0	194.08
194.09 VISITOR MEALS	0	0	0	0	194.09
194.10 NONREIMBURSABLE PROJECTS	0	0	0	0	194.10
194.11 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)	28,662	1,997,949	0	1,997,949	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B-1  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 CAP REL COSTS-BLDG & FIXT	31,487					1.00
2.00 CAP REL COSTS-MVBLE EQUIP		31,487				2.00
4.00 EMPLOYEE BENEFITS	116	116	1,484,104			4.00
5.00 ADMINISTRATIVE & GENERAL	2,778	2,778	320,009	-1,421,861	4,070,572	5.00
7.00 OPERATION OF PLANT	5,778	5,778	59,620	0	741,290	7.00
8.00 LAUNDRY & LINEN SERVICE	701	701	0	0	51,159	8.00
9.00 HOUSEKEEPING	522	522	0	0	130,852	9.00
10.00 DIETARY	1,639	1,639	0	0	234,098	10.00
11.00 CAFETERIA	1,498	1,498	0	0	93,099	11.00
13.00 NURSING ADMINISTRATION	220	220	286,231	0	362,558	13.00
14.00 CENTRAL SERVICES & SUPPLY	1,996	1,996	42,656	0	181,865	14.00
15.00 PHARMACY	985	985	0	0	193,791	15.00
16.00 MEDICAL RECORDS & LIBRARY	363	363	74,009	0	116,671	16.00
17.00 SOCIAL SERVICE	243	243	50,173	0	85,816	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	12,385	12,385	423,655	0	1,324,070	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	0	43.00
44.00 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	0	0	0	2,925	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	202	202	39,176	0	65,384	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	87	87	0	0	16,738	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	437	437	188,575	0	264,954	65.00
66.00 PHYSICAL THERAPY	886	886	0	0	76,108	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	17,487	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	69,995	73.00
74.00 RENAL DIALYSIS	651	651	0	0	41,712	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 PSYCHOLOGY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 CMHC	0	0	0	0	0	99.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B-1  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)				
	1.00	2.00				
99.10 CORF	0	0	0	0	0	99.10
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	31,487	31,487	1,484,104	-1,421,861	4,070,572	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01 IDLE SPACE	0	0	0	0	0	194.01
194.02 REG HOSPITAL OFFICE	0	0	0	0	0	194.02
194.03 REG NURSING OFFICE	0	0	0	0	0	194.03
194.04 PHYSICIAN OFFICE	0	0	0	0	0	194.04
194.05 CORP DATA CENTER	0	0	0	0	0	194.05
194.06 DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07 OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08 REHABCARE NURSING	0	0	0	0	0	194.08
194.09 VISITOR MEALS	0	0	0	0	0	194.09
194.10 NONREIMBURSABLE PROJECTS	0	0	0	0	0	194.10
194.11 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)	914,121	1,042,764	289,797		1,421,861	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	29.031696	33.117286	0.195267		0.349303	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			7,210		215,269	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.004858		0.052884	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B-1

Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (PATIENT DAYS)	CAFETERIA (CAFETERIA FTES)	
	7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT	22,815					7.00
8.00 LAUNDRY & LINEN SERVICE	701	656				8.00
9.00 HOUSEKEEPING	522	0	21,592			9.00
10.00 DIETARY	1,639	0	1,639	656		10.00
11.00 CAFETERIA	1,498	0	1,498	0	32	11.00
13.00 NURSING ADMINISTRATION	220	0	220	0	7	13.00
14.00 CENTRAL SERVICES & SUPPLY	1,996	0	1,996	0	2	14.00
15.00 PHARMACY	985	0	985	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	363	0	363	0	3	16.00
17.00 SOCIAL SERVICE	243	0	243	0	1	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	12,385	656	12,385	656	12	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00 SUBPROVIDER - 1 PF	0	0	0	0	0	40.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	0	43.00
44.00 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	202	0	202	0	1	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	87	0	87	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	437	0	437	0	6	65.00
66.00 PHYSICAL THERAPY	886	0	886	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	651	0	651	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 PSYCHOLOGY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B-1

Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (PATIENT DAYS)	CAFETERIA (CAFETERIA FTES)	
101.00 HOME HEALTH AGENCY	7.00	8.00	9.00	10.00	11.00	0 101.00
SPECIAL PURPOSE COST CENTERS						
105.00 KIDNEY ACQUISITION	0	0	0	0	0	0 105.00
106.00 HEART ACQUISITION	0	0	0	0	0	0 106.00
107.00 LIVER ACQUISITION	0	0	0	0	0	0 107.00
108.00 LUNG ACQUISITION	0	0	0	0	0	0 108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	0	0 109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	0 110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	0 111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	0 113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	0 114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	0 115.00
116.00 HOSPICE	0	0	0	0	0	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	22,815	656	21,592	656	32	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	0 190.00
191.00 RESEARCH	0	0	0	0	0	0 191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0 192.00
193.00 NONPAID WORKERS	0	0	0	0	0	0 193.00
194.00 NONALLOWABLE CASE MANAGER	0	0	0	0	0	0 194.00
194.01 IDLE SPACE	0	0	0	0	0	0 194.01
194.02 REG HOSPITAL OFFICE	0	0	0	0	0	0 194.02
194.03 REG NURSING OFFICE	0	0	0	0	0	0 194.03
194.04 PHYSICIAN OFFICE	0	0	0	0	0	0 194.04
194.05 CORP DATA CENTER	0	0	0	0	0	0 194.05
194.06 DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	0 194.06
194.07 OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	0 194.07
194.08 REHABCARE NURSING	0	0	0	0	0	0 194.08
194.09 VISITOR MEALS	0	0	0	0	0	0 194.09
194.10 NONREIMBURSABLE PROJECTS	0	0	0	0	0	0 194.10
194.11 NONREIMB NEW BUSINESS IMPLEMENTATION	0	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)	1,000,225	99,761	199,444	402,863	205,129	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	43.840675	152.074695	9.236940	614.120427	6,410.281250	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	398,589	58,518	48,482	146,556	127,557	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	17.470480	89.204268	2.245369	223.408537	3,986.156250	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B-1

Date/Time Prepared:  
2/27/2012 2:24 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	12					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	65,669				14.00
15.00	PHARMACY	0	4,207	71,105			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	219	0	2,742,104		16.00
17.00	SOCIAL SERVICE	0	0	0	0	656	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	12	25,605	1,110	931,935	656	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	755	0	14,017	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	3,736	0	27,978	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	1,062	0	189,862	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	11,407	0	281,514	0	65.00
66.00	PHYSICAL THERAPY	0	739	0	79,596	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,487	0	209,268	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	69,995	1,007,934	0	73.00
74.00	RENAL DIALYSIS	0	452	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	PSYCHOLOGY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet B-1

Date/Time Prepared:  
2/27/2012 2:24 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	
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	12	65,669	71,105	2,742,104	656	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01 IDLE SPACE	0	0	0	0	0	194.01
194.02 REG HOSPITAL OFFICE	0	0	0	0	0	194.02
194.03 REG NURSING OFFICE	0	0	0	0	0	194.03
194.04 PHYSICIAN OFFICE	0	0	0	0	0	194.04
194.05 CORP DATA CENTER	0	0	0	0	0	194.05
194.06 DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07 OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08 REHABCARE NURSING	0	0	0	0	0	194.08
194.09 VISITOR MEALS	0	0	0	0	0	194.09
194.10 NONREIMBURSABLE PROJECTS	0	0	0	0	0	194.10
194.11 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)	545,750	364,155	337,093	197,137	135,100	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	45,479.16667	5.545311	4.740778	0.071893	205.945122	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	66,479	181,199	102,493	48,810	28,662	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	5,539.916667	2.759278	1.441432	0.017800	43.692073	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2012 2:24 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS		3,918,583	4,533	3,923,116	30.00
31.00	INTENSIVE CARE UNIT		0	0	0	31.00
32.00	CORONARY CARE UNIT		0	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT		0	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT		0	0	0	34.00
40.00	SUBPROVIDER - I PF		0	0	0	40.00
41.00	SUBPROVIDER - IRF		0	0	0	41.00
42.00	SUBPROVIDER		0	0	0	42.00
43.00	NURSERY		0	0	0	43.00
44.00	SKILLED NURSING FACILITY		0	0	0	44.00
45.00	NURSING FACILITY		0	0	0	45.00
46.00	OTHER LONG TERM CARE		0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM		9,142	0	9,142	50.00
51.00	RECOVERY ROOM		0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	ANESTHESIOLOGY		0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC		128,083	0	128,083	54.00
55.00	RADIOLOGY-THERAPEUTIC		0	0	0	55.00
56.00	RADIOISOTOPE		0	0	0	56.00
57.00	CT SCAN		0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	LABORATORY		46,742	237	46,979	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.		0	0	0	63.00
64.00	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	RESPIRATORY THERAPY		502,654	0	502,654	65.00
66.00	PHYSICAL THERAPY		159,540	0	159,540	66.00
67.00	OCCUPATIONAL THERAPY		0	0	0	67.00
68.00	SPEECH PATHOLOGY		0	0	0	68.00
69.00	ELECTROCARDIOLOGY		0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		135,611	0	135,611	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		498,737	0	498,737	73.00
74.00	RENAL DIALYSIS		93,341	0	93,341	74.00
75.00	ASC (NON-DISTINCT PART)		0	0	0	75.00
76.00	PSYCHOLOGY		0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	CLINIC		0	0	0	90.00
91.00	EMERGENCY		0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00	HOME PROGRAM DIALYSIS		0	0	0	94.00
95.00	AMBULANCE SERVICES		0	0	0	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED		0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP-SOLD		0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS		0	0	0	98.00
99.00	CMHC		0	0	0	99.00
99.10	CORF		0	0	0	99.10
100.00	I & R SERVICES-NOT APPRVD PRGM		0	0	0	100.00
101.00	HOME HEALTH AGENCY		0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00	KIDNEY ACQUISITION		0	0	0	105.00
106.00	HEART ACQUISITION		0	0	0	106.00
107.00	LIVER ACQUISITION		0	0	0	107.00
108.00	LUNG ACQUISITION		0	0	0	108.00
109.00	PANCREAS ACQUISITION		0	0	0	109.00
110.00	INTESTINAL ACQUISITION		0	0	0	110.00
111.00	ISLET ACQUISITION		0	0	0	111.00
113.00	INTEREST EXPENSE		0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF		0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)		0	0	0	115.00
116.00	HOSPICE		0	0	0	116.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2012 2:24 pm

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	
200.00 Subtotal (see instructions)	5,492,433	0	5,492,433	4,770	5,497,203	200.00
201.00 Less Observation Beds	0		0		0	201.00
202.00 Total (see instructions)	5,492,433	0	5,492,433	4,770	5,497,203	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140306		Period: From 02/23/2011 To 08/31/2011		Worksheet C Part I Date/Time Prepared: 2/27/2012 2:24 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	931,935		931,935			30.00
31.00	INTENSIVE CARE UNIT	0		0			31.00
32.00	CORONARY CARE UNIT	0		0			32.00
33.00	BURN INTENSIVE CARE UNIT	0		0			33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
40.00	SUBPROVIDER - 1 PF	0		0			40.00
41.00	SUBPROVIDER - 1RF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
43.00	NURSERY	0		0			43.00
44.00	SKILLED NURSING FACILITY	0		0			44.00
45.00	NURSING FACILITY	0		0			45.00
46.00	OTHER LONG TERM CARE	0		0			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	14,017	0	14,017	0.652208	0.000000	50.00
51.00	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	27,657	321	27,978	4.577990	0.000000	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	183,949	5,913	189,862	0.246189	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	RESPIRATORY THERAPY	281,514	0	281,514	1.785538	0.000000	65.00
66.00	PHYSICAL THERAPY	76,329	3,267	79,596	2.004372	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	209,268	0	209,268	0.648025	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,007,934	0	1,007,934	0.494811	0.000000	73.00
74.00	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.00	PSYCHOLOGY	0	0	0	0.000000	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
95.00	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
97.00	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
99.00	CMHC	0	0	0			99.00
99.10	CORF	0	0	0			99.10
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
101.00	HOME HEALTH AGENCY	0	0	0			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
105.00	KIDNEY ACQUISITION	0	0	0			105.00
106.00	HEART ACQUISITION	0	0	0			106.00
107.00	LIVER ACQUISITION	0	0	0			107.00
108.00	LUNG ACQUISITION	0	0	0			108.00
109.00	PANCREAS ACQUISITION	0	0	0			109.00
110.00	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	ISLET ACQUISITION	0	0	0			111.00
113.00	INTEREST EXPENSE						113.00
114.00	UTILIZATION REVIEW-SNF						114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00	HOSPICE	0	0	0			116.00
200.00	Subtotal (see instructions)	2,732,603	9,501	2,742,104			200.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2012 2:24 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			
201.00 Less Observation Beds				9.00	10.00	201.00
202.00 Total (see instructions)	2,732,603	9,501	2,742,104			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet C Part I Date/Time Prepared: 2/27/2012 2:24 pm
Cost Center Description		PPS Inpatient Ratio 11.00	Title XVII	Hospital PPS
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
32.00	CORONARY CARE UNIT			32.00
33.00	BURN INTENSIVE CARE UNIT			33.00
34.00	SURGICAL INTENSIVE CARE UNIT			34.00
40.00	SUBPROVIDER - IPF			40.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
43.00	NURSERY			43.00
44.00	SKILLED NURSING FACILITY			44.00
45.00	NURSING FACILITY			45.00
46.00	OTHER LONG TERM CARE			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0.652208		50.00
51.00	RECOVERY ROOM	0.000000		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	4.577990		54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	RADIOISOTOPE	0.000000		56.00
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.247438		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	INTRAVENOUS THERAPY	0.000000		64.00
65.00	RESPIRATORY THERAPY	1.785538		65.00
66.00	PHYSICAL THERAPY	2.004372		66.00
67.00	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.648025		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.494811		73.00
74.00	RENAL DIALYSIS	0.000000		74.00
75.00	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	PSYCHOLOGY	0.000000		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	CLINIC	0.000000		90.00
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
94.00	HOME PROGRAM DIALYSIS	0.000000		94.00
95.00	AMBULANCE SERVICES	0.000000		95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
97.00	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
99.00	CMHC			99.00
99.10	CORF			99.10
100.00	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
105.00	KIDNEY ACQUISITION			105.00
106.00	HEART ACQUISITION			106.00
107.00	LIVER ACQUISITION			107.00
108.00	LUNG ACQUISITION			108.00
109.00	PANCREAS ACQUISITION			109.00
110.00	INTESTINAL ACQUISITION			110.00
111.00	ISLET ACQUISITION			111.00
113.00	INTEREST EXPENSE			113.00
114.00	UTILIZATION REVIEW-SNF			114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	HOSPICE			116.00
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: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2012 2:24 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	3,918,583		3,918,583	0	0 30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0 31.00
32.00	CORONARY CARE UNIT	0		0	0	0 32.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0 33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0 34.00
40.00	SUBPROVIDER - I PF	0		0	0	0 40.00
41.00	SUBPROVIDER - I RF	0		0	0	0 41.00
42.00	SUBPROVIDER	0		0	0	0 42.00
43.00	NURSERY	0		0	0	0 43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0 44.00
45.00	NURSING FACILITY	0		0	0	0 45.00
46.00	OTHER LONG TERM CARE	0		0	0	0 46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	9,142		9,142	0	0 50.00
51.00	RECOVERY ROOM	0		0	0	0 51.00
52.00	DELIVERY ROOM & LABOR ROOM	0		0	0	0 52.00
53.00	ANESTHESIOLOGY	0		0	0	0 53.00
54.00	RADIOLOGY-DIAGNOSTIC	128,083		128,083	0	0 54.00
55.00	RADIOLOGY-THERAPEUTIC	0		0	0	0 55.00
56.00	RADIOISOTOPE	0		0	0	0 56.00
57.00	CT SCAN	0		0	0	0 57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0 58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	LABORATORY	46,742		46,742	0	0 60.00
60.01	BLOOD LABORATORY	0		0	0	0 60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0 61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0 62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0 63.00
64.00	INTRAVENOUS THERAPY	0		0	0	0 64.00
65.00	RESPIRATORY THERAPY	502,654	0	502,654	0	0 65.00
66.00	PHYSICAL THERAPY	159,540	0	159,540	0	0 66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	ELECTROCARDIOLOGY	0		0	0	0 69.00
70.00	ELECTROENCEPHALOGRAPHY	0		0	0	0 70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	135,611		135,611	0	0 71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	498,737		498,737	0	0 73.00
74.00	RENAL DIALYSIS	93,341		93,341	0	0 74.00
75.00	ASC (NON-DISTINCT PART)	0		0	0	0 75.00
76.00	PSYCHOLOGY	0		0	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0		0	0	0 88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0 89.00
90.00	CLINIC	0		0	0	0 90.00
91.00	EMERGENCY	0		0	0	0 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00	HOME PROGRAM DIALYSIS	0		0	0	0 94.00
95.00	AMBULANCE SERVICES	0		0	0	0 95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0 96.00
97.00	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0 97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0		0	0	0 98.00
99.00	CMHC	0		0	0	0 99.00
99.10	CORF	0		0	0	0 99.10
100.00	I & R SERVICES-NOT APPRVD PRGM	0		0	0	0 100.00
101.00	HOME HEALTH AGENCY	0		0	0	0 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00	KIDNEY ACQUISITION	0		0	0	0 105.00
106.00	HEART ACQUISITION	0		0	0	0 106.00
107.00	LIVER ACQUISITION	0		0	0	0 107.00
108.00	LUNG ACQUISITION	0		0	0	0 108.00
109.00	PANCREAS ACQUISITION	0		0	0	0 109.00
110.00	INTESTINAL ACQUISITION	0		0	0	0 110.00
111.00	ISLET ACQUISITION	0		0	0	0 111.00
113.00	INTEREST EXPENSE	0		0	0	0 113.00
114.00	UTILIZATION REVIEW-SNF	0		0	0	0 114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0		0	0	0 115.00
116.00	HOSPICE	0		0	0	0 116.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2012 2:24 pm

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	
200.00 Subtotal (see instructions)	5,492,433	0	5,492,433	0	0	200.00
201.00 Less Observation Beds	0		0			0201.00
202.00 Total (see instructions)	5,492,433	0	5,492,433	0	0	0202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2012 2:24 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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	931,935		931,935			30.00
31.00	INTENSIVE CARE UNIT	0		0			31.00
32.00	CORONARY CARE UNIT	0		0			32.00
33.00	BURN INTENSIVE CARE UNIT	0		0			33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
40.00	SUBPROVIDER - 1 PF	0		0			40.00
41.00	SUBPROVIDER - 1RF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
43.00	NURSERY	0		0			43.00
44.00	SKILLED NURSING FACILITY	0		0			44.00
45.00	NURSING FACILITY	0		0			45.00
46.00	OTHER LONG TERM CARE	0		0			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	14,017	0	14,017	0.652208	0.000000	50.00
51.00	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	27,657	321	27,978	4.577990	0.000000	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	183,949	5,913	189,862	0.246189	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	RESPIRATORY THERAPY	281,514	0	281,514	1.785538	0.000000	65.00
66.00	PHYSICAL THERAPY	76,329	3,267	79,596	2.004372	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	209,268	0	209,268	0.648025	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,007,934	0	1,007,934	0.494811	0.000000	73.00
74.00	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.00	PSYCHOLOGY	0	0	0	0.000000	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
95.00	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
97.00	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
99.00	CMHC	0	0	0			99.00
99.10	CORF	0	0	0			99.10
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
101.00	HOME HEALTH AGENCY	0	0	0			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
105.00	KIDNEY ACQUISITION	0	0	0			105.00
106.00	HEART ACQUISITION	0	0	0			106.00
107.00	LIVER ACQUISITION	0	0	0			107.00
108.00	LUNG ACQUISITION	0	0	0			108.00
109.00	PANCREAS ACQUISITION	0	0	0			109.00
110.00	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	ISLET ACQUISITION	0	0	0			111.00
113.00	INTEREST EXPENSE						113.00
114.00	UTILIZATION REVIEW-SNF						114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00	HOSPICE	0	0	0			116.00
200.00	Subtotal (see instructions)	2,732,603	9,501	2,742,104			200.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2012 2:24 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			
201.00 Less Observation Beds				9.00	10.00	201.00
202.00 Total (see instructions)	2,732,603	9,501	2,742,104			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet C Part I Date/Time Prepared: 2/27/2012 2:24 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
32.00	CORONARY CARE UNIT			32.00
33.00	BURN INTENSIVE CARE UNIT			33.00
34.00	SURGICAL INTENSIVE CARE UNIT			34.00
40.00	SUBPROVIDER - IPF			40.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
43.00	NURSERY			43.00
44.00	SKILLED NURSING FACILITY			44.00
45.00	NURSING FACILITY			45.00
46.00	OTHER LONG TERM CARE			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0.000000		50.00
51.00	RECOVERY ROOM	0.000000		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	RADIOISOTOPE	0.000000		56.00
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.000000		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	INTRAVENOUS THERAPY	0.000000		64.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
67.00	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	RENAL DIALYSIS	0.000000		74.00
75.00	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	PSYCHOLOGY	0.000000		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	0.000000		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	CLINIC	0.000000		90.00
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
94.00	HOME PROGRAM DIALYSIS	0.000000		94.00
95.00	AMBULANCE SERVICES	0.000000		95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
97.00	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
99.00	CMHC			99.00
99.10	CORF			99.10
100.00	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
105.00	KIDNEY ACQUISITION			105.00
106.00	HEART ACQUISITION			106.00
107.00	LIVER ACQUISITION			107.00
108.00	LUNG ACQUISITION			108.00
109.00	PANCREAS ACQUISITION			109.00
110.00	INTESTINAL ACQUISITION			110.00
111.00	ISLET ACQUISITION			111.00
113.00	INTEREST EXPENSE			113.00
114.00	UTILIZATION REVIEW-SNF			114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	HOSPICE			116.00
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: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet D  
Part I  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,522,863	0	1,522,863	656	2,321.44	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	1,522,863		1,522,863	656		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet D Part I Date/Time Prepared: 2/27/2012 2:24 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
	6.00	7.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 ADULTS & PEDIATRICS	466	1,081,791		30.00
31.00 INTENSIVE CARE UNIT	0	0		31.00
32.00 CORONARY CARE UNIT	0	0		32.00
33.00 BURN INTENSIVE CARE UNIT	0	0		33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0		34.00
40.00 SUBPROVIDER - IPF	0	0		40.00
41.00 SUBPROVIDER - IRF	0	0		41.00
42.00 SUBPROVIDER	0	0		42.00
43.00 NURSERY	0	0		43.00
44.00 SKILLED NURSING FACILITY	0	0		44.00
45.00 NURSING FACILITY	0	0		45.00
200.00 Total (lines 30-199)	466	1,081,791		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet D  
Part II  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	2,488	14,017	0.177499	14,017	2,488	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	34,978	27,978	1.250197	24,628	30,790	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	14,317	189,862	0.075407	149,876	11,302	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	111,106	281,514	0.394673	227,225	89,680	65.00
66.00	PHYSICAL THERAPY	80,013	79,596	1.005239	57,618	57,920	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	52,901	209,268	0.252791	164,285	41,530	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	122,536	1,007,934	0.121571	677,768	82,397	73.00
74.00	RENAL DIALYSIS	56,747	0	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	PSYCHOLOGY	0	0	0.000000	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	0	0	0.000000	0	0	90.00
91.00	EMERGENCY	0	0	0.000000	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
97.00	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50-199)	475,086	1,810,169		1,315,417	316,107	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140306		Period: From 02/23/2011 To 08/31/2011		Worksheet D Part III Date/Time Prepared: 2/27/2012 2:24 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	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet D Part III Date/Time Prepared: 2/27/2012 2:24 pm
		Title XVIII	Hospital	PPS

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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 ADULTS & PEDIATRICS	656	0.00	466	0	30.00
31.00 INTENSIVE CARE UNIT	0	0.00	0	0	31.00
32.00 CORONARY CARE UNIT	0	0.00	0	0	32.00
33.00 BURN INTENSIVE CARE UNIT	0	0.00	0	0	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0.00	0	0	34.00
40.00 SUBPROVIDER - IPF	0	0.00	0	0	40.00
41.00 SUBPROVIDER - IRF	0	0.00	0	0	41.00
42.00 SUBPROVIDER	0	0.00	0	0	42.00
43.00 NURSERY	0	0.00	0	0	43.00
44.00 SKILLED NURSING FACILITY	0	0.00	0	0	44.00
45.00 NURSING FACILITY	0	0.00	0	0	45.00
200.00 Total (lines 30-199)	656		466	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	PSYCHOLOGY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	AMBULANCE SERVICES						95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	14,017	0.000000	0.000000	14,017	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	27,978	0.000000	0.000000	24,628	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	189,862	0.000000	0.000000	149,876	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	281,514	0.000000	0.000000	227,225	65.00
66.00	PHYSICAL THERAPY	0	79,596	0.000000	0.000000	57,618	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	209,268	0.000000	0.000000	164,285	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,007,934	0.000000	0.000000	677,768	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
76.00	PSYCHOLOGY	0	0	0.000000	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
95.00	AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
97.00	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00	Total (Lines 50-199)	0	1,810,169			1,315,417	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	321	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	56.00
57.00	CT SCAN	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	LABORATORY	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	PSYCHOLOGY	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	CLINIC	0	0	0	90.00
91.00	EMERGENCY	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	HOME PROGRAM DIALYSIS	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP-SOLD	0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
200.00	Total (Lines 50-199)	0	321	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet D Part V Date/Time Prepared: 2/27/2012 2:24 pm
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		Title XVIII			Hospital	PPS
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0.652208	0	0	0	50.00
51.00	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4.577990	321	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	CT SCAN	0.000000	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.246189	0	0	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	RESPIRATORY THERAPY	1.785538	0	0	0	65.00
66.00	PHYSICAL THERAPY	2.004372	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.648025	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.494811	0	0	0	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
76.00	PSYCHOLOGY	0.000000	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	CLINIC	0.000000	0	0	0	90.00
91.00	EMERGENCY	0.000000	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00	HOME PROGRAM DIALYSIS	0.000000		0		94.00
95.00	AMBULANCE SERVICES	0.000000		0		95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	98.00
200.00	Subtotal (see instructions)		321	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		321	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet D Part V Date/Time Prepared: 2/27/2012 2:24 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs			
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)	
	5.00	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,470	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	56.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00 PSYCHOLOGY	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 CLINIC	0	0	0	90.00
91.00 EMERGENCY	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
94.00 HOME PROGRAM DIALYSIS	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	95.00
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
97.00 DURABLE MEDICAL EQUIP-SOLD	0	0	0	97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
200.00 Subtotal (see instructions)	1,470	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00 Net Charges (line 200 +/- line 201)	1,470	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/27/2012 2:24 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		656	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		656	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		656	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)		466	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,923,116	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)		3,923,116	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		940,048	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		940,048	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		4.173315	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)		1,433.00	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)		3,923,116	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		5,980.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,786,848	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)		2,786,848	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140306		Period: From 02/23/2011 To 08/31/2011		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 2/27/2012 2:24 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)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT	0	0	0.00	0	0	0	44.00
45.00 BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	0	45.00
46.00 SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	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)						1,122,009	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						3,908,857	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)						1,081,791	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						316,107	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						1,397,898	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						2,510,959	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140306		Period: From 02/23/2011 To 08/31/2011		Worksheet D-1 Date/Time Prepared: 2/27/2012 2:24 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,522,863	3,923,116	0.388177	0	0	90.00
91.00	Nursing School cost	0	3,923,116	0.000000	0	0	91.00
92.00	Allied health cost	0	3,923,116	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,923,116	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 2/27/2012 2:24 pm
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		656	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		656	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		656	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)		41	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,918,583	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)		3,918,583	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		940,048	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		940,048	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		4.168492	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)		1,433.00	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)		3,918,583	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		5,973.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		244,911	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)		244,911	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140306		Period: From 02/23/2011 To 08/31/2011		Worksheet D-1	
Title XIX		Hospital		Cost			
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		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	0	0	0.00	0	0		44.00
45.00 BURN INTENSIVE CARE UNIT	0	0	0.00	0	0		45.00
46.00 SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0		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)					80,455		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					325,366		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		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		0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							0 61.00
62.00 Relief payment (see instructions)							0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)							0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)							0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)							0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		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: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet D-1  
Date/Time Prepared:  
2/27/2012 2:24 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet D-3 Date/Time Prepared: 2/27/2012 2:24 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		667,778		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
32.00	CORONARY CARE UNIT		0		32.00
33.00	BURN INTENSIVE CARE UNIT		0		33.00
34.00	SURGICAL INTENSIVE CARE UNIT		0		34.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.652208	14,017	9,142	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4.577990	24,628	112,747	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	RADIOISOTOPE	0.000000	0	0	56.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.247438	149,876	37,085	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	1.785538	227,225	405,719	65.00
66.00	PHYSICAL THERAPY	2.004372	57,618	115,488	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.648025	164,285	106,461	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.494811	677,768	335,367	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	PSYCHOLOGY	0.000000	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.000000	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
95.00	AMBULANCE SERVICES				95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
97.00	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		1,315,417	1,122,009	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)		1,315,417		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet D-3	
		Title XIX	Hospital	Date/Time Prepared: 2/27/2012 2:24 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		58,753		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
32.00	CORONARY CARE UNIT		0		32.00
33.00	BURN INTENSIVE CARE UNIT		0		33.00
34.00	SURGICAL INTENSIVE CARE UNIT		0		34.00
40.00	SUBPROVIDER - I PF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.652208	0	0	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4.577990	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	RADIOISOTOPE	0.000000	0	0	56.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.246189	0	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	1.785538	0	0	65.00
66.00	PHYSICAL THERAPY	2.004372	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.648025	2,774	1,798	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.494811	158,963	78,657	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	PSYCHOLOGY	0.000000	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.000000	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
95.00	AMBULANCE SERVICES				95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
97.00	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		161,737	80,455	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)		161,737		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet E Part A Date/Time Prepared: 2/27/2012 2:24 pm
		Title VIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		129,192	1.00
2.00	Outlier payments for discharges. (see instructions)		146,940	2.00
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		50.00	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		276,132	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		276,132	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,188,213	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00
57.00	Routine service other pass through costs		0	57.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet E Part A Date/Time Prepared: 2/27/2012 2:24 pm
		Title XVIII	Hospital	PPS
				1.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			1,464,345 59.00
60.00	Primary payer payments			0 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			1,464,345 61.00
62.00	Deductibles billed to program beneficiaries			0 62.00
63.00	Coinsurance billed to program beneficiaries			55,468 63.00
64.00	Allowable bad debts (see instructions)			0 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			0 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			1,408,877 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			0 70.96
70.97	Low Volume Payment-2			0 70.97
70.98	Low Volume Payment-3			0 70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			1,408,877 71.00
72.00	Interim payments			220,663 72.00
73.00	Tentative settlement (for contractor use only)			0 73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)			1,188,214 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Operating outlier amount from Worksheet E, Part A line 2			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet E Part B Date/Time Prepared: 2/27/2012 2:24 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			1,470 2.00
3.00	PPS payments			41 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			0 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			41 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			8 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			33 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			33 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			33 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			33 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			33 40.00
41.00	Interim payments			33 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)			0 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/27/2012 2:24 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		220,663		33	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		220,663		33	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		1,188,214		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,408,877		33	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2012 2:24 pm
		Title XIX	Hospital	Cost
				1.00
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services		325,366	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)		325,366	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)		325,366	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges		58,753	8.00
9.00	Ancillary service charges		161,737	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)		220,490	12.00
<b>CUSTOMARY CHRGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		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	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		220,490	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		104,876	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		220,490	21.00
<b>PROSPECTIVE PAYMENT AMOUNT</b>				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		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	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		220,490	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)		104,876	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		220,490	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		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)		220,490	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		220,490	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)		220,490	40.00
41.00	Interim payments		25,426	41.00
42.00	Balance due provider/program (line 40 minus 41)		195,064	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

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

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet G

Date/Time Prepared:  
2/27/2012 2:24 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	300	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	333,348	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	774,809	0	0	0	6.00
7.00	Inventory	117,797	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)	1,226,254	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	865,944	0	0	0	12.00
13.00	Land improvements	10,963	0	0	0	13.00
14.00	Accumulated depreciation	-543	0	0	0	14.00
15.00	Buildings	21,007,686	0	0	0	15.00
16.00	Accumulated depreciation	-886,076	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	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	2,963,232	0	0	0	23.00
24.00	Accumulated depreciation	-346,176	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)	23,615,030	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	72,267	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	72,267	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,913,551	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	199,362	0	0	0	37.00
38.00	Salaries, wages, and fees payable	189,450	0	0	0	38.00
39.00	Payroll taxes payable	6,805	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	340,649	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	736,266	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	29,334,046	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	29,334,046	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	30,070,312	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	-5,156,761	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)	-5,156,761	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,913,551	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet G-1

Date/Time Prepared:  
2/27/2012 2:24 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
		1.00	Fund balances at beginning of period		0		
2.00	Net income (loss) (From Wkst. G-3, line 29)		-3,119,497			2.00	
3.00	Total (sum of line 1 and line 2)		-3,119,497		0	3.00	
4.00	Additions (credit adjustments)	0		0		4.00	
5.00	INTERCOMPANY TRANSFERS\ROUNDING	0		0		5.00	
6.00		0		0		6.00	
7.00		0		0		7.00	
8.00		0		0		8.00	
9.00		0		0		9.00	
10.00	Total additions (sum of line 4-9)		0		0	10.00	
11.00	Subtotal (line 3 plus line 10)		-3,119,497		0	11.00	
12.00	Deductions (debit adjustments)	0		0		12.00	
13.00	INTERCOMPANY TRANSFERS\ROUNDING	2,037,264		0		13.00	
14.00		0		0		14.00	
15.00		0		0		15.00	
16.00		0		0		16.00	
17.00		0		0		17.00	
18.00	Total deductions (sum of lines 12-17)		2,037,264		0	18.00	
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-5,156,761		0	19.00	

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet G-1

Date/Time Prepared:  
2/27/2012 2:24 pm

	Endowment Fund		Plant Fund			
	5.00	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		0			4.00
5.00 INTERCOMPANY TRANSFERS\ROUNDING	0		0			5.00
6.00	0		0			6.00
7.00	0		0			7.00
8.00	0		0			8.00
9.00	0		0			9.00
10.00 Total additions (sum of line 4-9)		0		0		10.00
11.00 Subtotal (line 3 plus line 10)		0		0		11.00
12.00 Deductions (debit adjustments)	0		0			12.00
13.00 INTERCOMPANY TRANSFERS\ROUNDING	0		0			13.00
14.00	0		0			14.00
15.00	0		0			15.00
16.00	0		0			16.00
17.00	0		0			17.00
18.00 Total deductions (sum of lines 12-17)		0		0		18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet G-2 Parts

Date/Time Prepared:  
2/27/2012 2:24 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	931,935		931,935	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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	0		0	8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	931,935		931,935	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	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)	931,935		931,935	17.00
18.00	Ancillary services	1,800,668	9,501	1,810,169	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	0	0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC	0	0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	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)	2,732,603	9,501	2,742,104	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		4,342,985		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)		4,342,985		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140306

Period:  
From 02/23/2011  
To 08/31/2011

Worksheet G-3

Date/Time Prepared:  
2/27/2012 2:24 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	2,742,104	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,520,968	2.00
3.00	Net patient revenues (line 1 minus line 2)	1,221,136	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	4,342,985	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,121,849	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	128	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	1,662	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	0	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	546	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	16	24.00
25.00	Total other income (sum of lines 6-24)	2,352	25.00
26.00	Total (line 5 plus line 25)	-3,119,497	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)	-3,119,497	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140306	Period: From 02/23/2011 To 08/31/2011	Worksheet L Parts I-III Date/Time Prepared: 2/27/2012 2:24 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		0	1.00
2.00	Capital DRG outlier payments		0	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		0.00	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		0	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		1,081,791	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		316,107	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		1,397,898	3.00
4.00	Capital cost payment factor (see instructions)		85	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		1,188,213	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00