

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: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet S Parts I-III Date/Time Prepared: 3/20/2012 4:59 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 3/20/2012	Time: 4:59 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 ABRAHAM LINCOLN MEMORIAL HOSPITAL for the cost reporting period beginning 10/01/2010 and ending 09/30/2011 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.

Encryption Information
 ECR: Date: 3/20/2012 Time: 4:59 pm
 TsPLzx15kc: 8xL07i 2EXhV8JokrgLO
 SMVe20CuFj fL: w4DddG0X0S4F0PSC.
 rgRQ0aLmBz0NMZbf
 PI: Date: 3/20/2012 Time: 4:59 pm
 0x: S6sscQFdQkH0wXv1FAi 1Yvj wF60
 T1eRs0ZqJN2Sj 1FEHTMw6Hvh3i 3bX
 nR. 5F8USR90oWi I I

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

 Title

 Date

	Title V 1.00	Title XVII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	366,490	119,584	0	0 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	190,270	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	556,760	119,584	0	0 200.00

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: 141322		Period: From 10/01/2010 To 09/30/2011		Worksheet S-2 Part I Date/Time Prepared: 3/20/2012 4:57 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 200 STAHLHUT DRIVE		PO Box:						1.00		
2.00	City: LINCOLN		State: IL		Zip Code: 62656		County: LOGAN		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		ABRAHAM LINCOLN MEMORIAL HOSPITAL	141322	99914	1	02/01/2003	N	O	N	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		ABRAHAM LINCOLN MEMORIAL HOSPITAL	14Z322	99914		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF							N		N	8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA							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										17.00
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)					10/01/2010		09/30/2011		20.00	
21.00	Type of Control (see instructions)							2		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.					0				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	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	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.							2		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.							2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0		35.00	

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		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for 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	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME 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	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1 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		
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	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 1.00	XIX 2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	N	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
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		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)		Y		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)		N	N	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 1.00	Occupational 2.00	Speech 3.00	Respiratory 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	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		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.			2	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.		25,000,000	25,000,000	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.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00

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		1.00	2.00										
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00									
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00									
All Providers													
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H058	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: MEMORIAL HEALTH SYSTEM	Contractor's Name: MEMORIAL HEALTH SYSTEM		Contractor's Number: 14H058		141.00							
142.00	Street: 701 NORTH FIRST STREET	PO Box:				142.00							
143.00	City: SPRINGFIELD	State: 17		Zip Code: 62781		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.	N		145.00									
				1.00									
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	N		N		158.00							
159.00	SNF	N		N		159.00							
160.00	HOME HEALTH AGENCY	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	
												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: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part II Date/Time Prepared: 3/20/2012 4:57 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	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			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	01/13/2012	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part II Date/Time Prepared: 3/20/2012 4:57 pm
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		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
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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
Interest Expense					
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		Y		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
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		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
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		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	
PS&R Data		3.00	4.00	
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	01/13/2012	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: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center	Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
		Line Number		Avai lable		
		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	25	9,125	80,264.00	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)		25	9,125	80,264.00	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	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	43.00				13.00
14.00	Total (see instructions)		25	9,125	80,264.00	14.00
15.00	CAH visits					15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					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					25.00
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)		25			27.00
28.00	Observation Bed Days					28.00
29.00	Ambulance Trips					29.00
30.00	Employee discount days (see instruction)					30.00
31.00	Employee discount days - IRF					31.00
32.00	Labor & delivery days (see instructions)					32.00
33.00	LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	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	1,877	590	3,188	1.00	
2.00 HMO		0	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	639	0	639	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	112	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,516	590	3,939	7.00	
8.00 INTENSIVE CARE UNIT	0	0	0	0	8.00	
9.00 CORONARY CARE UNIT					9.00	
10.00 BURN INTENSIVE CARE UNIT					10.00	
11.00 SURGICAL INTENSIVE CARE UNIT					11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00	
13.00 NURSERY	0		337	454	13.00	
14.00 Total (see instructions)	0	2,516	927	4,393	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF					17.00	
18.00 SUBPROVIDER					18.00	
19.00 SKILLED NURSING FACILITY					19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					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					25.00	
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		39	116	28.00	
29.00 Ambulance Trips		0			29.00	
30.00 Employee discount days (see instruction)				58	30.00	
31.00 Employee discount days - IRF				0	31.00	
32.00 Labor & delivery days (see instructions)			0	30	32.00	
33.00 LTCH non-covered days		0			33.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
3/20/2012 4:57 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	517	1.00
2.00 HMO					0	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	253.65	0.00	0	517	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						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						25.00
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	253.65	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
3/20/2012 4:57 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)	234	1,046		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)	234	1,046		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet S-10 Date/Time Prepared: 3/20/2012 4:57 pm
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				1.00		
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.493943		1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		1,885,150		2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N		4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		2,711,924		5.00	
6.00	Medicaid charges		9,833,989		6.00	
7.00	Medicaid cost (line 1 times line 6)		4,857,430		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)		260,356		8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone SCHIP		23,660		9.00	
10.00	Stand-alone SCHIP charges		84,176		10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		41,578		11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		17,918		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)		278,274		19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				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		3,764,147	250,617	4,014,764	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		1,859,274	123,791	1,983,065	21.00
22.00	Partial payment by patients approved for charity care		998,978	0	998,978	22.00
23.00	Cost of charity care (line 21 minus line 22)		860,296	123,791	984,087	23.00
				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		25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,547,119		26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		541,003		27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		1,006,116		28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		496,964		29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,481,051		30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,759,325		31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet A
Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT		2,170,222	2,170,222	1,641,904	3,812,126	1.00
2.00 CAP REL COSTS-MVBLE EQUIP		1,195,348	1,195,348	89,423	1,284,771	2.00
3.00 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 EMPLOYEE BENEFITS	133,661	4,000,754	4,134,415	0	4,134,415	4.00
5.00 ADMIN STRATIVE & GENERAL	1,544,010	5,203,600	6,747,610	-191,193	6,556,417	5.00
7.00 OPERATION OF PLANT	460,812	806,420	1,267,232	0	1,267,232	7.00
8.00 LAUNDRY & LINEN SERVICE	0	0	0	165,876	165,876	8.00
9.00 HOUSEKEEPING	385,588	226,109	611,697	-165,876	445,821	9.00
10.00 DIETARY	468,697	346,558	815,255	-536,935	278,320	10.00
11.00 CAFETERIA	0	0	0	536,418	536,418	11.00
13.00 NURSING ADMINISTRATION	404,209	259,098	663,307	-10,179	653,128	13.00
14.00 CENTRAL SERVICES & SUPPLY	248,026	258,658	506,684	-195,040	311,644	14.00
15.00 PHARMACY	395,126	1,019,979	1,415,105	-984,904	430,201	15.00
16.00 MEDICAL RECORDS & LIBRARY	426,618	118,677	545,295	0	545,295	16.00
17.00 SOCIAL SERVICE	0	0	0	37,650	37,650	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,508,430	308,260	1,816,690	694,639	2,511,329	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00 NURSERY	0	0	0	134,555	134,555	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	772,166	796,450	1,568,616	-121,446	1,447,170	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	843,953	125,720	969,673	-829,944	139,729	52.00
53.00 ANESTHESIOLOGY	800,354	75,721	876,075	0	876,075	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,025,850	938,469	1,964,319	-49,324	1,914,995	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	808,172	1,177,937	1,986,109	0	1,986,109	60.00
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	303,470	136,077	439,547	0	439,547	65.00
66.00 PHYSICAL THERAPY	1,028,722	155,846	1,184,568	0	1,184,568	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	61,193	0	61,193	0	61,193	68.00
69.00 ELECTROCARDIOLOGY	50,215	58,011	108,226	0	108,226	69.00
69.01 CARDIAC REHAB	95,679	23,073	118,752	0	118,752	69.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	109,726	109,726	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	206,952	206,952	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	1,047,414	1,047,414	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
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER CLINIC	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	1,290,190	1,897,586	3,187,776	-39,582	3,148,194	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	1,540,134	1,540,134	-1,540,134	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)	13,055,141	22,838,707	35,893,848	0	35,893,848	118.00
NONREIMBURSABLE COST CENTERS						
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 CARE-A-VAN	30,636	5,851	36,487	0	36,487	194.00
200.00 TOTAL (SUM OF LINES 118-199)	13,085,777	22,844,558	35,930,335	0	35,930,335	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet A
Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	-188,285	3,623,841	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	143,589	1,428,360	2.00
3.00	OTHER CAP REL COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	-405,150	3,729,265	4.00
5.00	ADMINISTRATIVE & GENERAL	-337,015	6,219,402	5.00
7.00	OPERATION OF PLANT	-147,766	1,119,466	7.00
8.00	LAUNDRY & LINEN SERVICE	0	165,876	8.00
9.00	HOUSEKEEPING	-55,463	390,358	9.00
10.00	DIETARY	0	278,320	10.00
11.00	CAFETERIA	-89,087	447,331	11.00
13.00	NURSING ADMINISTRATION	-640	652,488	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	311,644	14.00
15.00	PHARMACY	-8,381	421,820	15.00
16.00	MEDICAL RECORDS & LIBRARY	-9,278	536,017	16.00
17.00	SOCIAL SERVICE	0	37,650	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	2,511,329	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
43.00	NURSERY	0	134,555	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	1,447,170	50.00
51.00	RECOVERY ROOM	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	-451	139,278	52.00
53.00	ANESTHESIOLOGY	-815,552	60,523	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,914,995	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	-23,033	1,963,076	60.00
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	-8,235	431,312	65.00
66.00	PHYSICAL THERAPY	-41,362	1,143,206	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	61,193	68.00
69.00	ELECTROCARDIOLOGY	0	108,226	69.00
69.01	CARDIAC REHAB	0	118,752	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	109,726	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	206,952	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,047,414	73.00
74.00	RENAL DIALYSIS	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS				
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	-1,277,268	1,870,926	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
94.00	HOME PROGRAM DIALYSIS	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
101.00	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
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)	-3,263,377	32,630,471	118.00
NONREIMBURSABLE COST CENTERS				
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	CARE-A-VAN	0	36,487	194.00
200.00	TOTAL (SUM OF LINES 118-199)	-3,263,377	32,666,958	200.00

RECLASSIFICATIONS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-6
Date/Time Prepared:
3/20/2012 4:57 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - RECLASS STERILE PROCESSING SALARIES						
1.00	OPERATING ROOM	50.00	52,202	0	1.00	
	TOTALS		52,202	0		
B - RECLASS LABOR AND DELIVERY EXPENSES						
1.00	NURSERY	43.00	117,164	17,391	1.00	
2.00	ADULTS & PEDIATRICS	30.00	605,512	89,877	2.00	
	TOTALS		722,676	107,268		
C - RECLASS SOCIAL SERVICE FEES						
1.00	SOCIAL SERVICE	17.00	0	37,650	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		0	37,650		
D - RECLASS PROPERTY INSURANCE						
1.00	OTHER CAP REL COSTS	3.00	0	66,017	1.00	
	TOTALS		0	66,017		
E - RECLASS DRUG EXPENSE						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,047,414	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
	TOTALS		0	1,047,414		
F - RECLASS LAUNDRY EXPENSE						
1.00	LAUNDRY & LINEN SERVICE	8.00	30,499	135,377	1.00	
	TOTALS		30,499	135,377		
G - MEDICAL SUPPLY AND IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	109,726	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	206,952	2.00	
3.00		0.00	0	0	3.00	
	TOTALS		0	316,678		
H - RECLASS CAFETERIA EXPENSE						
1.00	CAFETERIA	11.00	308,587	227,831	1.00	
	TOTALS		308,587	227,831		
I - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,483,925	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	47,315	2.00	
	TOTALS		0	1,531,240		
J - RECLASS BOND AMORTIZATION EXPENSE						
1.00	OTHER CAP REL COSTS	3.00	0	134,070	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		0	134,070		
500.00	Grand Total: Increases		1,113,964	3,603,545	500.00	

RECLASSIFICATIONS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-6
Date/Time Prepared:
3/20/2012 4:57 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - RECLASS STERILE PROCESSING SALARIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	52,202	0	0		1.00
	TOTALS		52,202	0			
B - RECLASS LABOR AND DELIVERY EXPENSES							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	722,676	107,268	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		722,676	107,268			
C - RECLASS SOCIAL SERVICE FEES							
1.00	ADULTS & PEDIATRICS	30.00	0	750	0		1.00
2.00	EMERGENCY	91.00	0	36,900	0		2.00
	TOTALS		0	37,650			
D - RECLASS PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	66,017	5		1.00
	TOTALS		0	66,017			
E - RECLASS DRUG EXPENSE							
1.00	DIETARY	10.00	0	517	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	10,179	0		2.00
3.00	PHARMACY	15.00	0	984,712	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	49,324	0		4.00
5.00	EMERGENCY	91.00	0	2,682	0		5.00
	TOTALS		0	1,047,414			
F - RECLASS LAUNDRY EXPENSE							
1.00	HOUSEKEEPING	9.00	30,499	135,377	0		1.00
	TOTALS		30,499	135,377			
G - MEDICAL SUPPLY AND IMPLANTS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	142,838	0		1.00
2.00	PHARMACY	15.00	0	192	0		2.00
3.00	OPERATING ROOM	50.00	0	173,648	0		3.00
	TOTALS		0	316,678			
H - RECLASS CAFETERIA EXPENSE							
1.00	DIETARY	10.00	308,587	227,831	0		1.00
	TOTALS		308,587	227,831			
I - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	1,531,240	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	1,531,240			
J - RECLASS BOND AMORTIZATION EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	125,176	14		1.00
2.00	INTEREST EXPENSE	113.00	0	8,894	0		2.00
	TOTALS		0	134,070			
500.00	Grand Total: Decreases		1,113,964	3,603,545			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
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	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	967,836	125,000	0	125,000	156,014	1.00
2.00	Land Improvements	283,990	5,784,294	0	5,784,294	283,990	2.00
3.00	Buildings and Fixtures	18,288,890	41,190,725	0	41,190,725	18,066,248	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	10,217,061	5,355,898	0	5,355,898	2,742,730	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,757,777	52,455,917	0	52,455,917	21,248,982	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	29,757,777	52,455,917	0	52,455,917	21,248,982	10.00
SUMMARY OF CAPITAL							
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
	9.00	10.00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,170,222	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,195,348	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,365,570	0	0	0	0	3.00
COMPUTATION OF RATIOS							
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	48,134,483	0	48,134,483	0.789547	52,124	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,830,229	0	12,830,229	0.210453	13,893	2.00
3.00	Total (sum of lines 1-2)	60,964,712	0	60,964,712	1.000000	66,017	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
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		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	936,822	0		1.00	
2.00	Land Improvements	5,784,294	0		2.00	
3.00	Buildings and Fixtures	41,413,367	0		3.00	
4.00	Building Improvements	0	0		4.00	
5.00	Fixed Equipment	0	0		5.00	
6.00	Movable Equipment	12,830,229	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	60,964,712	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	60,964,712	0		10.00	
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	2,170,222		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,195,348		2.00	
3.00	Total (sum of lines 1-2)	0	3,365,570		3.00	
ALLOCATION OF OTHER CAPITAL						
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
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	105,855	157,979	2,150,710	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	28,215	42,108	1,344,318	0 2.00
3.00	Total (sum of lines 1-2)	0	134,070	200,087	3,495,028	0 3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,315,152	52,124	0	105,855	3,623,841	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	41,934	13,893	0	28,215	1,428,360	2.00
3.00	Total (sum of lines 1-2)	1,357,086	66,017	0	134,070	5,052,201	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8

Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line #	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-168,773	CAP REL COSTS-BLDG & FIXT		1.00	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-5,381	CAP REL COSTS-MVBLE EQUIP		2.00	2.00
3.00 Investment income - other (chapter 2)	B	-2,507	ADMINISTRATIVE & GENERAL		5.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	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)		0			0.00	7.00
8.00 Television and radio service (chapter 21)	A	-4,638	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	-1,296,857				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	299,904				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Cafeteria-employees and guests	B	-89,087	CAFETERIA		11.00	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	B	-9,278	MEDICAL RECORDS & LIBRARY		16.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	19.00
20.00 Vending machines		0			0.00	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	0	RESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF		114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP 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	0	OCCUPATIONAL THERAPY		67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	32.00
33.00 PHARMACY REBATES	B	-8,381	PHARMACY		15.00	33.00
33.01 ADMINISTRATIVE REBATES	B	-33,153	ADMINISTRATIVE & GENERAL		5.00	33.01
33.02 NURSING ADMIN MISCELLANEOUS REVENUE	B	-640	NURSING ADMINISTRATION		13.00	33.02
33.03 LABORATORY MISCELLANEOUS REVENUE	B	-3,895	LABORATORY		60.00	33.03
33.04 RESPIRATORY MISCELLANEOUS REVENUE	B	-8,235	RESPIRATORY THERAPY		65.00	33.04
33.05 PHYSICAL THERAPY MISCELLANEOUS REVENUE	B	-41,362	PHYSICAL THERAPY		66.00	33.05
33.06 MISCELLANEOUS REVENUE	B	-115,296	ADMINISTRATIVE & GENERAL		5.00	33.06
33.07 CORPORATE OVERHEAD	B	-14,040	ADMINISTRATIVE & GENERAL		5.00	33.07
33.08 LAPSING FY 92 ADDITION	A	1,637	CAP REL COSTS-MVBLE EQUIP		2.00	33.08
33.09 CRNA SALARIES	A	-800,354	ANESTHESIOLOGY		53.00	33.09
33.10 CRNA BENEFITS RECLASS	A	-69,123	EMPLOYEE BENEFITS		4.00	33.10
33.11 CRNA CONTRACT EXPENSE	A	-15,198	ANESTHESIOLOGY		53.00	33.11
33.12 MARKETING SALARY	A	-37,068	ADMINISTRATIVE & GENERAL		5.00	33.12
33.13 MARKETING BENEFITS EXPENSE	A	-9,812	EMPLOYEE BENEFITS		4.00	33.13
33.14 MARKETING OTHER EXPENSE	A	-58,501	ADMINISTRATIVE & GENERAL		5.00	33.14
33.15 ADVERTISING EXPENSE	A	-67,953	ADMINISTRATIVE & GENERAL		5.00	33.15
33.16 LOBBYING EXPENSE	A	-16,235	ADMINISTRATIVE & GENERAL		5.00	33.16
33.17 PROVIDER TAX	A	-439,816	ADMINISTRATIVE & GENERAL		5.00	33.17
33.18 PROVIDER TAX ASSISTANCE PAYMENT	A	-23,451	ADMINISTRATIVE & GENERAL		5.00	33.18

Provider CCN: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet A-8 Date/Time Prepared: 3/20/2012 4:57 pm
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center	Line #	
			1.00	2.00	
33.19 CLINIC DEPRECIATION	A	-27,293	CAP REL COSTS-BLDG & FIXT	1.00	33.19
33.20 CLINIC OPERATION OF PLANT	A	-143,128	OPERATION OF PLANT	7.00	33.20
33.21 CLINIC HOUSEKEEPING	A	-55,463	HOUSEKEEPING	9.00	33.21
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,263,377			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8
Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description		Wkst. A-7 Ref.		
		5.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	11		1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	11		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 - CAP REL COSTS-BLDG & FIXT	0		26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	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	PHARMACY REBATES	0		33.00
33.01	ADMINISTRATIVE REBATES	0		33.01
33.02	NURSING ADMINISTRATIVE MISCELLANEOUS REVENUE	0		33.02
33.03	LABORATORY MISCELLANEOUS REVENUE	0		33.03
33.04	RESPIRATORY MISCELLANEOUS REVENUE	0		33.04
33.05	PHYSICAL THERAPY MISCELLANEOUS REVENUE	0		33.05
33.06	MISCELLANEOUS REVENUE	0		33.06
33.07	CORPORATE OVERHEAD	0		33.07
33.08	LAPSING FY 92 ADDITION	9		33.08
33.09	CRNA SALARIES	0		33.09
33.10	CRNA BENEFITS RECLASS	0		33.10
33.11	CRNA CONTRACT EXPENSE	0		33.11
33.12	MARKETING SALARY	0		33.12
33.13	MARKETING BENEFITS EXPENSE	0		33.13
33.14	MARKETING OTHER EXPENSE	0		33.14
33.15	ADVERTISING EXPENSE	0		33.15
33.16	LOBBYING EXPENSE	0		33.16
33.17	PROVIDER TAX	0		33.17
33.18	PROVIDER TAX ASSISTANCE PAYMENT	0		33.18
33.19	CLINIC DEPRECIATION	9		33.19
33.20	CLINIC OPERATION OF PLANT	0		33.20
33.21	CLINIC HOUSEKEEPING	0		33.21
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: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-1

Date/Time Prepared:
3/20/2012 4:57 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		1.00CAP REL COSTS-BLDG & FIXT	HO BUILDING CAPITAL	1.00
2.00		2.00CAP REL COSTS-MVBLE EQUIP	MO MME CAPITAL	2.00
3.00		5.00ADMINISTRATIVE & GENERAL	HO INTEREST OPERATING	3.00
4.00		5.00ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	4.00
4.01		4.00EMPLOYEE BENEFITS	SELF INSURANCE BENEFITS	4.01
4.02		14.00CENTRAL SERVICES & SUPPLY	INVENTORY ITEMS	4.02
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. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00		B	0.00	6.00
7.00		B	0.00	7.00
8.00		B	0.00	8.00
9.00		B	0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet A-8-1 Date/Time Prepared: 3/20/2012 4:57 pm
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	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	7,781	0	7,781	9	1.00
2.00	147,333	0	147,333	9	2.00
3.00	22,046	0	22,046	0	3.00
4.00	2,361,090	1,912,131	448,959	0	4.00
4.01	1,472,478	1,798,693	-326,215	0	4.01
4.02	57,863	57,863	0	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	4,068,591	3,768,687	299,904	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		MEMORIAL HL SYS	100.00	MANAGEMENT/HO	6.00
7.00		MEMORIAL MD CTR	0.00	HOSPITAL	7.00
8.00		TAYLORVILLE MC	0.00	HOSPITAL	8.00
9.00		MEMORIAL HOME S	0.00	HOME HEALTH	9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
3/20/2012 4:57 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	60.00	LAB AGGRAGATE	19,138	19,138	1.00
2.00	5.00	MEDICAL DIRECTOR	581	0	2.00
3.00	91.00	ER AGGRAGATE	1,551,158	1,277,268	3.00
4.00	53.00	MEDICAL DIRECTOR	1,021	0	4.00
5.00	69.01	MEDICAL DIRECTOR	4,198	0	5.00
6.00	13.00	MEDICAL DIRECTOR	1,822	0	6.00
7.00	52.00	D&L AGGRAGATE	451	451	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)	1,578,369	1,296,857	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2
Date/Time Prepared:
3/20/2012 4:57 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	581	0	0	0	0	2.00
3.00	273,890	0	0	0	0	3.00
4.00	1,021	0	0	0	0	4.00
5.00	4,198	0	0	0	0	5.00
6.00	1,822	0	0	0	0	6.00
7.00	0	0	0	0	0	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	281,512		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2
Date/Time Prepared:
3/20/2012 4:57 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	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	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	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2
Date/Time Prepared:
3/20/2012 4:57 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	19,138	1.00
2.00	0	0	2.00
3.00	0	1,277,268	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	451	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	1,296,857	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
3/20/2012 4:57 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	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	3,623,841	3,623,841			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,428,360		1,428,360		2.00
4.00	EMPLOYEE BENEFITS	3,729,265	1,914	0	3,731,179	4.00
5.00	ADMINISTRATIVE & GENERAL	6,219,402	405,148	406,509	464,120	5.00
7.00	OPERATION OF PLANT	1,119,466	875,641	58,413	141,925	7.00
8.00	LAUNDRY & LINEN SERVICE	165,876	16,156	0	9,393	8.00
9.00	HOUSEKEEPING	390,358	72,905	4,512	109,363	9.00
10.00	DIETARY	278,320	120,776	991	49,312	10.00
11.00	CAFETERIA	447,331	40,719	42,196	95,041	11.00
13.00	NURSING ADMINISTRATION	652,488	42,413	0	124,492	13.00
14.00	CENTRAL SERVICES & SUPPLY	311,644	81,281	1,041	60,311	14.00
15.00	PHARMACY	421,820	34,852	14,718	121,694	15.00
16.00	MEDICAL RECORDS & LIBRARY	536,017	94,801	463	131,393	16.00
17.00	SOCIAL SERVICE	37,650	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,511,329	591,927	51,944	651,068	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	31.00
43.00	NURSERY	134,555	21,865	7,611	36,085	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,447,170	368,068	134,674	253,895	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	139,278	26,194	7,878	37,352	52.00
53.00	ANESTHESIOLOGY	60,523	6,713	44,172	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,914,995	217,114	492,031	315,949	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	1,963,076	124,195	56,235	248,907	60.00
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	431,312	18,195	15,933	93,465	65.00
66.00	PHYSICAL THERAPY	1,143,206	164,914	18,820	316,834	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	61,193	1,757	0	18,847	68.00
69.00	ELECTROCARDIOLOGY	108,226	15,622	34,054	15,466	69.00
69.01	CARDIAC REHAB	118,752	72,748	5,397	29,468	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	109,726	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	206,952	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,047,414	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
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	1,870,926	176,521	30,768	397,363	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
101.00	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
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)	32,630,471	3,592,439	1,428,360	3,721,743	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	20,924	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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
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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	
194.00 CARE-A-VAN	36,487	10,478	0	9,436	56,401	194.00
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	32,666,958	3,623,841	1,428,360	3,731,179	32,666,958	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	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	7,495,179					5.00
7.00	OPERATION OF PLANT	653,718	2,849,163				7.00
8.00	LAUNDRY & LINEN SERVICE	56,999	19,662	268,086			8.00
9.00	HOUSEKEEPING	171,849	88,725	808	838,520		9.00
10.00	DIETARY	133,813	146,984	797	44,969	775,962	10.00
11.00	CAFETERIA	186,186	49,555	1,534	15,161	0	11.00
13.00	NURSING ADMINISTRATION	243,983	51,616	55	15,792	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	135,266	98,918	422	30,263	0	14.00
15.00	PHARMACY	176,597	42,415	0	12,977	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	227,095	115,373	0	35,297	0	16.00
17.00	SOCIAL SERVICE	11,211	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,133,363	720,376	80,876	220,391	750,374	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	59,587	26,610	797	8,141	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	656,208	447,939	32,979	137,044	25,588	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	62,739	31,878	4,137	9,753	0	52.00
53.00	ANESTHESIOLOGY	33,173	8,170	0	2,500	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	875,444	264,228	38,281	80,839	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	712,367	151,145	107	46,242	0	60.00
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	166,420	22,143	0	6,775	0	65.00
66.00	PHYSICAL THERAPY	489,452	200,700	26,748	61,403	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	24,356	2,138	0	654	0	68.00
69.00	ELECTROCARDIOLOGY	51,622	19,012	6,541	5,817	0	69.00
69.01	CARDIAC REHAB	67,403	88,534	0	27,086	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	32,672	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	61,622	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	311,879	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
OUTPATIENT SERVICE COST CENTERS							
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	737,131	214,826	68,000	65,724	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
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)	7,472,155	2,810,947	262,082	826,828	775,962	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,230	25,465	0	7,791	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	6,004	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	CARE-A-VAN	16,794	12,751	0	3,901	0	194.00
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	7,495,179	2,849,163	268,086	838,520	775,962	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
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	877,723					11.00
13.00 NURSING ADMINISTRATION	32,092	1,162,931				13.00
14.00 CENTRAL SERVICES & SUPPLY	30,431	1,533	751,110			14.00
15.00 PHARMACY	23,256	0	1,088	849,417		15.00
16.00 MEDICAL RECORDS & LIBRARY	60,508	0	38	0	1,200,985	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	185,131	479,990	62,611	0	255,562	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00 NURSERY	8,836	22,940	2,232	0	15,679	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	81,114	209,022	125,758	0	114,846	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	9,154	23,750	2,310	0	8,231	52.00
53.00 ANESTHESIOLOGY	17,318	44,702	11,484	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	88,112	0	37,940	40,413	78,393	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	93,696	0	264,389	0	74,474	60.00
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	28,770	71,531	3,807	0	13,719	65.00
66.00 PHYSICAL THERAPY	90,762	0	15,152	0	9,015	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	4,347	0	6	0	0	68.00
69.00 ELECTROCARDIOLOGY	5,089	13,156	558	0	30,965	69.00
69.01 CARDIAC REHAB	7,952	23,526	987	0	0	69.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	54,048	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	101,938	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	806,807	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
OUTPATIENT SERVICE COST CENTERS						
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	104,864	272,781	66,764	2,197	547,578	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
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)	871,432	1,162,931	751,110	849,417	1,148,462	118.00
NONREIMBURSABLE COST CENTERS						
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	43,900	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 CARE-A-VAN	6,291	0	0	0	8,623	194.00
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	877,723	1,162,931	751,110	849,417	1,200,985	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00 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	48,861				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	963	7,695,905	0	7,695,905	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	31.00
43.00 NURSERY	0	344,938	0	344,938	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	4,034,305	0	4,034,305	50.00
51.00 RECOVERY ROOM	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	362,654	0	362,654	52.00
53.00 ANESTHESIOLOGY	0	228,755	0	228,755	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	4,443,739	0	4,443,739	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	3,734,833	0	3,734,833	60.00
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	872,070	0	872,070	65.00
66.00 PHYSICAL THERAPY	0	2,537,006	0	2,537,006	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	113,298	0	113,298	68.00
69.00 ELECTROCARDIOLOGY	0	306,128	0	306,128	69.00
69.01 CARDIAC REHAB	0	441,853	0	441,853	69.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	196,446	0	196,446	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	370,512	0	370,512	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	2,166,100	0	2,166,100	73.00
74.00 RENAL DIALYSIS	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
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	47,898	4,603,341	0	4,603,341	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS					
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	95.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
101.00 HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
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)	48,861	32,451,883	0	32,451,883	118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	60,410	0	60,410	190.00
191.00 RESEARCH	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	49,904	0	49,904	192.00
193.00 NONPAID WORKERS	0	0	0	0	193.00
194.00 CARE-A-VAN	0	104,761	0	104,761	194.00
200.00 Cross Foot Adjustments		0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	17.00	24.00	25.00	26.00		
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118-201)	48,861	32,666,958	0	32,666,958		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part II
Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	1,914	0	1,914	1,914 4.00
5.00	ADMINISTRATIVE & GENERAL	11,918	405,148	406,509	823,575	238 5.00
7.00	OPERATION OF PLANT	8,569	875,641	58,413	942,623	73 7.00
8.00	LAUNDRY & LINEN SERVICE	0	16,156	0	16,156	5 8.00
9.00	HOUSEKEEPING	0	72,905	4,512	77,417	56 9.00
10.00	DIETARY	0	120,776	991	121,767	25 10.00
11.00	CAFETERIA	0	40,719	42,196	82,915	49 11.00
13.00	NURSING ADMINISTRATION	0	42,413	0	42,413	64 13.00
14.00	CENTRAL SERVICES & SUPPLY	189	81,281	1,041	82,511	31 14.00
15.00	PHARMACY	0	34,852	14,718	49,570	62 15.00
16.00	MEDICAL RECORDS & LIBRARY	0	94,801	463	95,264	67 16.00
17.00	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	27,769	591,927	51,944	671,640	333 30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
43.00	NURSERY	0	21,865	7,611	29,476	19 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	35,427	368,068	134,674	538,169	130 50.00
51.00	RECOVERY ROOM	0	0	0	0	0 51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	26,194	7,878	34,072	19 52.00
53.00	ANESTHESIOLOGY	3,096	6,713	44,172	53,981	0 53.00
54.00	RADIOLOGY-DIAGNOSTIC	172,734	217,114	492,031	881,879	162 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	212	124,195	56,235	180,642	128 60.00
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	748	18,195	15,933	34,876	48 65.00
66.00	PHYSICAL THERAPY	5,618	164,914	18,820	189,352	163 66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	SPEECH PATHOLOGY	0	1,757	0	1,757	10 68.00
69.00	ELECTROCARDIOLOGY	0	15,622	34,054	49,676	8 69.00
69.01	CARDIAC REHAB	0	72,748	5,397	78,145	15 69.01
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
OUTPATIENT SERVICE COST CENTERS						
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	323	176,521	30,768	207,612	204 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0 94.00
95.00	AMBULANCE SERVICES	0	0	0	0	0 95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
101.00	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
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)	266,603	3,592,439	1,428,360	5,287,402	1,909 118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,924	0	20,924	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	CARE-A-VAN	0	10,478	0	10,478	5 194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part II
Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
200.00 Cross Foot Adjustments	0	1.00	2.00	2A	4.00	
201.00 Negative Cost Centers		0	0	0	0	200.00
202.00 TOTAL (sum lines 118-201)	266,603	3,623,841	1,428,360	5,318,804	1,914	201.00 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141322		Period: From 10/01/2010 To 09/30/2011		Worksheet B Part II Date/Time Prepared: 3/20/2012 4:57 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	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	823,813					5.00
7.00	OPERATION OF PLANT	71,853	1,014,549				7.00
8.00	LAUNDRY & LINEN SERVICE	6,265	7,001	29,427			8.00
9.00	HOUSEKEEPING	18,889	31,594	89	128,045		9.00
10.00	DIETARY	14,708	52,339	87	6,867	195,793	10.00
11.00	CAFETERIA	20,464	17,646	168	2,315	0	11.00
13.00	NURSING ADMINISTRATION	26,817	18,380	6	2,411	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	14,868	35,224	46	4,621	0	14.00
15.00	PHARMACY	19,410	15,104	0	1,982	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	24,961	41,083	0	5,390	0	16.00
17.00	SOCIAL SERVICE	1,232	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	124,563	256,514	8,879	33,657	189,337	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	6,549	9,475	87	1,243	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	72,126	159,505	3,620	20,927	6,456	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	6,896	11,351	454	1,489	0	52.00
53.00	ANESTHESIOLOGY	3,646	2,909	0	382	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	96,223	94,088	4,202	12,344	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	78,299	53,821	12	7,061	0	60.00
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	18,292	7,885	0	1,034	0	65.00
66.00	PHYSICAL THERAPY	53,797	71,467	2,936	9,376	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	2,677	761	0	100	0	68.00
69.00	ELECTROCARDIOLOGY	5,674	6,770	718	888	0	69.00
69.01	CARDIAC REHAB	7,408	31,526	0	4,136	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,591	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	6,773	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	34,280	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
OUTPATIENT SERVICE COST CENTERS							
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	81,021	76,497	7,464	10,036	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
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)	821,282	1,000,940	28,768	126,259	195,793	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	685	9,068	0	1,190	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	659	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	CARE-A-VAN	1,846	4,541	0	596	0	194.00
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	823,813	1,014,549	29,427	128,045	195,793	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141322		Period: From 10/01/2010 To 09/30/2011		Worksheet B Part II Date/Time Prepared: 3/20/2012 4:57 pm	
Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
	11.00	13.00	14.00	15.00	16.00		
GENERAL SERVICE COST CENTERS							
1.00							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	123,557						11.00
13.00	4,518	94,609					13.00
14.00	4,284	125	141,710				14.00
15.00	3,274	0	205	89,607			15.00
16.00	8,518	0	7	0	175,290		16.00
17.00	0	0	0	0	0		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	26,059	39,049	11,813	0	37,301		30.00
31.00	0	0	0	0	0		31.00
43.00	1,244	1,866	421	0	2,288		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	11,418	17,005	23,726	0	16,762		50.00
51.00	0	0	0	0	0		51.00
52.00	1,289	1,932	436	0	1,201		52.00
53.00	2,438	3,637	2,167	0	0		53.00
54.00	12,403	0	7,158	4,263	11,442		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	13,190	0	49,883	0	10,870		60.00
61.00							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	4,050	5,819	718	0	2,002		65.00
66.00	12,777	0	2,859	0	1,316		66.00
67.00	0	0	0	0	0		67.00
68.00	612	0	1	0	0		68.00
69.00	716	1,070	105	0	4,520		69.00
69.01	1,119	1,914	186	0	0		69.01
70.00	0	0	0	0	0		70.00
71.00	0	0	10,197	0	0		71.00
72.00	0	0	19,232	0	0		72.00
73.00	0	0	0	85,112	0		73.00
74.00	0	0	0	0	0		74.00
75.00	0	0	0	0	0		75.00
OUTPATIENT SERVICE COST CENTERS							
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	14,762	22,192	12,596	232	79,922		91.00
92.00							92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	0	0	0	0	0		94.00
95.00	0	0	0	0	0		95.00
98.00	0	0	0	0	0		98.00
101.00	0	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	0	0	0	0	0		113.00
114.00	0	0	0	0	0		114.00
115.00	0	0	0	0	0		115.00
116.00	0	0	0	0	0		116.00
118.00	122,671	94,609	141,710	89,607	167,624		118.00
NONREIMBURSABLE COST CENTERS							
190.00	0	0	0	0	0		190.00
191.00	0	0	0	0	0		191.00
192.00	0	0	0	0	6,407		192.00
193.00	0	0	0	0	0		193.00
194.00	886	0	0	0	1,259		194.00
200.00							200.00
201.00	0	0	0	0	0		201.00
202.00	123,557	94,609	141,710	89,607	175,290		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141322		Period: From 10/01/2010 To 09/30/2011		Worksheet B Part II Date/Time Prepared: 3/20/2012 4:57 pm	
Cost Center	Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	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	1,232					17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	24	1,399,169	0	1,399,169		30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0		31.00
43.00	NURSERY	0	52,668	0	52,668		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	869,844	0	869,844		50.00
51.00	RECOVERY ROOM	0	0	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	59,139	0	59,139		52.00
53.00	ANESTHESIOLOGY	0	69,160	0	69,160		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,124,164	0	1,124,164		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	393,906	0	393,906		60.00
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY						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	74,724	0	74,724		65.00
66.00	PHYSICAL THERAPY	0	344,043	0	344,043		66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0	5,918	0	5,918		68.00
69.00	ELECTROCARDIOLOGY	0	70,145	0	70,145		69.00
69.01	CARDIAC REHAB	0	124,449	0	124,449		69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,788	0	13,788		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	26,005	0	26,005		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	119,392	0	119,392		73.00
74.00	RENAL DIALYSIS	0	0	0	0		74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
OUTPATIENT SERVICE COST CENTERS							
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	1,208	513,746	0	513,746		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0		94.00
95.00	AMBULANCE SERVICES	0	0	0	0		95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
101.00	HOME HEALTH AGENCY	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
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)	1,232	5,260,260	0	5,260,260		118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	31,867	0	31,867		190.00
191.00	RESEARCH	0	0	0	0		191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	7,066	0	7,066		192.00
193.00	NONPAID WORKERS	0	0	0	0		193.00
194.00	CARE-A-VAN	0	19,611	0	19,611		194.00
200.00	Cross Foot Adjustments		0	0	0		200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part II
Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	17.00	24.00	25.00	26.00		
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118-201)	1,232	5,318,804	0	5,318,804		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1
Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	115,518				1.00
2.00	CAP REL COSTS-MVBLE EQUIP		1,386,252			2.00
4.00	EMPLOYEE BENEFITS	61	0	12,114,694		4.00
5.00	ADMINISTRATIVE & GENERAL	12,915	394,525	1,506,942	-7,495,179	25,171,779 5.00
7.00	OPERATION OF PLANT	27,913	56,691	460,812	0	2,195,445 7.00
8.00	LAUNDRY & LINEN SERVICE	515	0	30,499	0	191,425 8.00
9.00	HOUSEKEEPING	2,324	4,379	355,089	0	577,138 9.00
10.00	DIETARY	3,850	962	160,110	0	449,399 10.00
11.00	CAFETERIA	1,298	40,952	308,587	0	625,287 11.00
13.00	NURSING ADMINISTRATION	1,352	0	404,209	0	819,393 13.00
14.00	CENTRAL SERVICES & SUPPLY	2,591	1,010	195,824	0	454,277 14.00
15.00	PHARMACY	1,111	14,284	395,126	0	593,084 15.00
16.00	MEDICAL RECORDS & LIBRARY	3,022	449	426,618	0	762,674 16.00
17.00	SOCIAL SERVICE	0	0	0	0	37,650 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	18,869	50,413	2,113,942	0	3,806,268 30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
43.00	NURSERY	697	7,387	117,164	0	200,116 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	11,733	130,704	824,368	0	2,203,807 50.00
51.00	RECOVERY ROOM	0	0	0	0	0 51.00
52.00	DELIVERY ROOM & LABOR ROOM	835	7,646	121,277	0	210,702 52.00
53.00	ANESTHESIOLOGY	214	42,870	0	0	111,408 53.00
54.00	RADIOLOGY-DIAGNOSTIC	6,921	477,526	1,025,850	0	2,940,089 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	3,959	54,577	808,172	0	2,392,413 60.00
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	580	15,463	303,470	0	558,905 65.00
66.00	PHYSICAL THERAPY	5,257	18,265	1,028,722	0	1,643,774 66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	SPEECH PATHOLOGY	56	0	61,193	0	81,797 68.00
69.00	ELECTROCARDIOLOGY	498	33,050	50,215	0	173,368 69.00
69.01	CARDIAC REHAB	2,319	5,238	95,679	0	226,365 69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	109,726 71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	206,952 72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,047,414 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
OUTPATIENT SERVICE COST CENTERS						
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	5,627	29,861	1,290,190	0	2,475,578 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0 94.00
95.00	AMBULANCE SERVICES	0	0	0	0	0 95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
101.00	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
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)	114,517	1,386,252	12,084,058	-7,495,179	25,094,454 118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	667	0	0	0	20,924 190.00
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	CARE-A-VAN	334	0	30,636	0	56,401 194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1
Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	3,623,841	1,428,360	3,731,179		7,495,179	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	31.370358	1.030375	0.307988		0.297761	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			1,914		823,813	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000158		0.032728	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1

Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
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	74,629					7.00
8.00 LAUNDRY & LINEN SERVICE	515	184,770				8.00
9.00 HOUSEKEEPING	2,324	557	71,790			9.00
10.00 DIETARY	3,850	549	3,850	18,620		10.00
11.00 CAFETERIA	1,298	1,057	1,298	0	24,834	11.00
13.00 NURSING ADMINISTRATION	1,352	38	1,352	0	908	13.00
14.00 CENTRAL SERVICES & SUPPLY	2,591	291	2,591	0	861	14.00
15.00 PHARMACY	1,111	0	1,111	0	658	15.00
16.00 MEDICAL RECORDS & LIBRARY	3,022	0	3,022	0	1,712	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	18,869	55,742	18,869	18,006	5,238	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00 NURSERY	697	549	697	0	250	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	11,733	22,730	11,733	614	2,295	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	835	2,851	835	0	259	52.00
53.00 ANESTHESIOLOGY	214	0	214	0	490	53.00
54.00 RADIOLOGY-DIAGNOSTIC	6,921	26,384	6,921	0	2,493	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	3,959	74	3,959	0	2,651	60.00
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	580	0	580	0	814	65.00
66.00 PHYSICAL THERAPY	5,257	18,435	5,257	0	2,568	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	56	0	56	0	123	68.00
69.00 ELECTROCARDIOLOGY	498	4,508	498	0	144	69.00
69.01 CARDIAC REHAB	2,319	0	2,319	0	225	69.01
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
OUTPATIENT SERVICE COST CENTERS						
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	5,627	46,867	5,627	0	2,967	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
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)	73,628	180,632	70,789	18,620	24,656	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	667	0	667	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	4,138	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 CARE-A-VAN	334	0	334	0	178	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1

Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
	7.00	8.00	9.00	10.00	11.00	
202.00 Cost to be allocated (per Wkst. B, Part I)	2,849,163	268,086	838,520	775,962	877,723	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	38.177692	1.450917	11.680178	41.673577	35.343602	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	1,014,549	29,427	128,045	195,793	123,557	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	13.594568	0.159263	1.783605	10.515199	4.975316	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1

Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description		NURSING ADMINISTRATIVE (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
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	186,606					13.00
14.00	CENTRAL SERVICES & SUPPLY	246	1,524,881				14.00
15.00	PHARMACY	0	2,208	1,036,718			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	78	0	3,064		16.00
17.00	SOCIAL SERVICE	0	0	0	0	355	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	77,020	127,111	0	652	7	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	3,681	4,532	0	40	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	33,540	255,310	0	293	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	3,811	4,690	0	21	0	52.00
53.00	ANESTHESIOLOGY	7,173	23,315	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	77,025	49,324	200	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	536,755	0	190	0	60.00
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	11,478	7,729	0	35	0	65.00
66.00	PHYSICAL THERAPY	0	30,761	0	23	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	12	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	2,111	1,132	0	79	0	69.00
69.01	CARDIAC REHAB	3,775	2,003	0	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	109,726	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	206,952	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	984,712	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
OUTPATIENT SERVICE COST CENTERS							
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	43,771	135,542	2,682	1,397	348	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
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)	186,606	1,524,881	1,036,718	2,930	355	118.00
NONREIMBURSABLE COST CENTERS							
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	112	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	CARE-A-VAN	0	0	0	22	0	194.00
200.00	Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1

Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
	13.00	14.00	15.00	16.00	17.00	
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,162,931	751,110	849,417	1,200,985	48,861	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	6.232013	0.492570	0.819333	391.966384	137.636620	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	94,609	141,710	89,607	175,290	1,232	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.506999	0.092932	0.086433	57.209530	3.470423	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
3/20/2012 4:57 pm

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		7,695,905	0	0	30.00
31.00	INTENSIVE CARE UNIT		0	0	0	31.00
43.00	NURSERY		344,938	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		4,034,305	0	0	50.00
51.00	RECOVERY ROOM		0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM		362,654	0	0	52.00
53.00	ANESTHESIOLOGY		228,755	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC		4,443,739	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		3,734,833	0	0	60.00
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	872,070	0	0	65.00
66.00	PHYSICAL THERAPY	0	2,537,006	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	113,298	0	0	68.00
69.00	ELECTROCARDIOLOGY		306,128	0	0	69.00
69.01	CARDIAC REHAB		441,853	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		196,446	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		370,512	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		2,166,100	0	0	73.00
74.00	RENAL DIALYSIS		0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)		0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
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		4,603,341	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		226,019	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	HOME PROGRAM DIALYSIS		0	0	0	94.00
95.00	AMBULANCE SERVICES		0	0	0	95.00
98.00	OTHER REIMBURSABLE COST CENTERS		0	0	0	98.00
101.00	HOME HEALTH AGENCY		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
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)		32,677,902	0	0	200.00
201.00	Less Observation Beds		226,019			201.00
202.00	Total (see instructions)		32,451,883	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141322		Period: From 10/01/2010 To 09/30/2011		Worksheet C Part I Date/Time Prepared: 3/20/2012 4:57 pm	
		Title XVII		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	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,870,286		3,870,286			30.00
31.00	INTENSIVE CARE UNIT	0		0			31.00
43.00	NURSERY	290,184		290,184			43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,016,257	4,149,163	5,165,420	0.781022	0.000000	50.00
51.00	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	830,601	903,982	1,734,583	0.209073	0.000000	52.00
53.00	ANESTHESIOLOGY	276,298	539,736	816,034	0.280325	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	972,486	18,424,745	19,397,231	0.229091	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	1,493,750	9,947,638	11,441,388	0.326432	0.000000	60.00
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	468,492	1,011,280	1,479,772	0.589327	0.000000	65.00
66.00	PHYSICAL THERAPY	337,748	3,536,721	3,874,469	0.654801	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	SPEECH PATHOLOGY	21,887	125,936	147,823	0.766444	0.000000	68.00
69.00	ELECTROCARDIOLOGY	294,375	857,523	1,151,898	0.265760	0.000000	69.00
69.01	CARDIAC REHAB	0	371,616	371,616	1.189004	0.000000	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	818,143	429,876	1,248,019	0.157406	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	727,839	197,982	925,821	0.400198	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,233,566	4,688,829	6,922,395	0.312912	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
OUTPATIENT SERVICE COST CENTERS							
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	7,885	7,201,118	7,209,003	0.638554	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	111,301	111,301	2.030701	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
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
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
101.00	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS							
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)	13,659,797	52,497,446	66,157,243			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	13,659,797	52,497,446	66,157,243			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 3/20/2012 4:57 pm
Cost Center Description		PPS Inpatient Ratio	Title XVII	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
43.00	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
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
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
69.01	CARDIAC REHAB	0.000000		69.01
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
OUTPATIENT SERVICE COST CENTERS				
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
OTHER REIMBURSABLE COST CENTERS				
94.00	HOME PROGRAM DIALYSIS	0.000000		94.00
95.00	AMBULANCE SERVICES	0.000000		95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
101.00	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
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 ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part II Date/Time Prepared: 3/20/2012 4:57 pm
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Cost Center Description		Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	869,844	5,165,420	0.168398	190,670	32,108	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	59,139	1,734,583	0.034094	7,417	253	52.00
53.00	ANESTHESIOLOGY	69,160	816,034	0.084751	42,368	3,591	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,124,164	19,397,231	0.057955	621,071	35,994	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	393,906	11,441,388	0.034428	818,095	28,165	60.00
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	74,724	1,479,772	0.050497	294,978	14,896	65.00
66.00	PHYSICAL THERAPY	344,043	3,874,469	0.088797	188,046	16,698	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	5,918	147,823	0.040034	14,856	595	68.00
69.00	ELECTROCARDIOLOGY	70,145	1,151,898	0.060895	238,059	14,497	69.00
69.01	CARDIAC REHAB	124,449	371,616	0.334886	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,788	1,248,019	0.011048	357,729	3,952	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	26,005	925,821	0.028089	297,504	8,357	72.00
73.00	DRUGS CHARGED TO PATIENTS	119,392	6,922,395	0.017247	982,449	16,944	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
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	513,746	7,209,003	0.071265	1,692	121	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	111,301	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
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
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (Lines 50-199)	3,808,423	61,996,773		4,054,934	176,171	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 3/20/2012 4:57 pm
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Cost Center Description	Title XVIII				Hospital	Cost	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	0	60.00
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
69.01 CARDIAC REHAB	0	0	0	0	0	0	69.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	0	0	95.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00 Total (Lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description		Title XVIII			Hospital		Inpatient Program Charges	
		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)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	0	5,165,420	0.000000	0.000000	190,670	50.00	
51.00	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00	
52.00	DELIVERY ROOM & LABOR ROOM	0	1,734,583	0.000000	0.000000	7,417	52.00	
53.00	ANESTHESIOLOGY	0	816,034	0.000000	0.000000	42,368	53.00	
54.00	RADIOLOGY-DIAGNOSTIC	0	19,397,231	0.000000	0.000000	621,071	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	11,441,388	0.000000	0.000000	818,095	60.00	
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	1,479,772	0.000000	0.000000	294,978	65.00	
66.00	PHYSICAL THERAPY	0	3,874,469	0.000000	0.000000	188,046	66.00	
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00	
68.00	SPEECH PATHOLOGY	0	147,823	0.000000	0.000000	14,856	68.00	
69.00	ELECTROCARDIOLOGY	0	1,151,898	0.000000	0.000000	238,059	69.00	
69.01	CARDIAC REHAB	0	371,616	0.000000	0.000000	0	69.01	
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,248,019	0.000000	0.000000	357,729	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	925,821	0.000000	0.000000	297,504	72.00	
73.00	DRUGS CHARGED TO PATIENTS	0	6,922,395	0.000000	0.000000	982,449	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	
OUTPATIENT SERVICE COST CENTERS								
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	7,209,003	0.000000	0.000000	1,692	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	111,301	0.000000	0.000000	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
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	
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00	
200.00	Total (Lines 50-199)	0	61,996,773			4,054,934	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 3/20/2012 4:57 pm
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Cost Center Description	Title XVIII			Hospital	Cost	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 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
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
69.01 CARDIAC REHAB	0	0	0	0	0	69.01
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
OUTPATIENT SERVICE COST CENTERS						
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
OTHER REIMBURSABLE COST CENTERS						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES						95.00
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: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 3/20/2012 4:57 pm
Title XVIII		Hospital	Cost

Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
	23.00	24.00	
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0	0	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	0	0	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	0	0	60.00
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	0	65.00
66.00 PHYSICAL THERAPY	0	0	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
69.01 CARDIAC REHAB	0	0	69.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 RENAL DIALYSIS	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS			
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
OTHER REIMBURSABLE COST CENTERS			
94.00 HOME PROGRAM DIALYSIS	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	95.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00 Total (Lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/20/2012 4:57 pm
		Title XVIII	Hospital	Cost

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		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.781022	0	1,659,778	0	50.00
51.00	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.209073	0	6,953	0	52.00
53.00	ANESTHESIOLOGY	0.280325	0	156,939	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.229091	0	7,065,944	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	0.326432	0	4,092,415	0	60.00
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	0.589327	0	340,979	0	65.00
66.00	PHYSICAL THERAPY	0.654801	0	1,356,902	0	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.766444	0	17,380	0	68.00
69.00	ELECTROCARDIOLOGY	0.265760	0	438,924	0	69.00
69.01	CARDIAC REHAB	1.189004	0	207,671	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157406	0	229,976	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.400198	0	132,942	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.312912	0	2,850,302	5,469	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
OUTPATIENT SERVICE COST CENTERS						
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	0.638554	0	2,272,589	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2.030701	0	47,831	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	HOME PROGRAM DIALYSIS	0.000000		0		94.00
95.00	AMBULANCE SERVICES	0.000000		0		95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	98.00
200.00	Subtotal (see instructions)		0	20,877,525	5,469	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	20,877,525	5,469	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/20/2012 4:57 pm
	Title XVIII	Hospital	Cost

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	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	1,296,323	0	50.00
51.00 RECOVERY ROOM	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	1,454	0	52.00
53.00 ANESTHESIOLOGY	0	43,994	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	1,618,744	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	1,335,895	0	60.00
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	200,948	0	65.00
66.00 PHYSICAL THERAPY	0	888,501	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	13,321	0	68.00
69.00 ELECTROCARDIOLOGY	0	116,648	0	69.00
69.01 CARDIAC REHAB	0	246,922	0	69.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	36,200	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	53,203	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	891,894	1,711	73.00
74.00 RENAL DIALYSIS	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS				
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	1,451,171	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	97,130	0	92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 HOME PROGRAM DIALYSIS		0	0	94.00
95.00 AMBULANCE SERVICES		0	0	95.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
200.00 Subtotal (see instructions)	0	8,292,348	1,711	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	8,292,348	1,711	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/20/2012 4:57 pm		
		Component CCN: 14Z322	Title XVIII		Swing Beds - SNF Cost	
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		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.781022	0	0	0	50.00
51.00	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.209073	0	0	0	52.00
53.00	ANESTHESIOLOGY	0.280325	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.229091	0	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	0.326432	0	0	0	60.00
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	0.589327	0	0	0	65.00
66.00	PHYSICAL THERAPY	0.654801	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.766444	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.265760	0	0	0	69.00
69.01	CARDIAC REHAB	1.189004	0	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157406	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.400198	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.312912	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
OUTPATIENT SERVICE COST CENTERS						
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	0.638554	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2.030701	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	HOME PROGRAM DIALYSIS	0.000000		0		94.00
95.00	AMBULANCE SERVICES	0.000000		0		95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	98.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141322	Period: From 10/01/2010	Worksheet D Part V Date/Time Prepared: 3/20/2012 4:57 pm
	Component CCN: 14Z322	To 09/30/2011	
Title XVIII		Swing Beds - SNF	Cost

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	
ANCILLARY SERVICE COST CENTERS				
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	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
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
69.01 CARDIAC REHAB	0	0	0	69.01
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
OUTPATIENT SERVICE COST CENTERS				
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
OTHER REIMBURSABLE COST CENTERS				
94.00 HOME PROGRAM DIALYSIS		0	0	94.00
95.00 AMBULANCE SERVICES		0	0	95.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
200.00 Subtotal (see instructions)	0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1 Date/Time Prepared: 3/20/2012 4:57 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,055 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,304 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)			3,304 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			160 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)			479 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			28 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)			84 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,877 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)			160 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)			479 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			117.79 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			117.79 20.00
21.00	Total general inpatient routine service cost (see instructions)			7,695,905 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)			3,298 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)			9,894 25.00
26.00	Total swing-bed cost (see instructions)			1,258,245 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			6,437,660 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			3,500,700 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			3,500,700 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			1.838964 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)			1,059.53 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)			6,437,660 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,948.44 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,657,222 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)			3,657,222 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141322		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1	
		Title XVIII		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						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,427,173	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,084,395	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					311,750	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					933,303	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,245,053	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)					116	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,948.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					226,019	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141322		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1 Date/Time Prepared: 3/20/2012 4:57 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	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: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 3/20/2012 4:57 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		2,017,385		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.781022	190,670	148,917	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.209073	7,417	1,551	52.00
53.00	ANESTHESIOLOGY	0.280325	42,368	11,877	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.229091	621,071	142,282	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	0.326432	818,095	267,052	60.00
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	0.589327	294,978	173,838	65.00
66.00	PHYSICAL THERAPY	0.654801	188,046	123,133	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.766444	14,856	11,386	68.00
69.00	ELECTROCARDIOLOGY	0.265760	238,059	63,267	69.00
69.01	CARDIAC REHAB	1.189004	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157406	357,729	56,309	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.400198	297,504	119,061	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.312912	982,449	307,420	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
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	0.638554	1,692	1,080	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2.030701	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
95.00	AMBULANCE SERVICES				95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		4,054,934	1,427,173	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		4,054,934		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3	
		Component CCN: 14Z322		Date/Time Prepared: 3/20/2012 4:57 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		295,991		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.781022	0	0	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.209073	0	0	52.00
53.00	ANESTHESIOLOGY	0.280325	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.229091	54,136	12,402	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	0.326432	117,829	38,463	60.00
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	0.589327	81,734	48,168	65.00
66.00	PHYSICAL THERAPY	0.654801	85,546	56,016	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.766444	1,775	1,360	68.00
69.00	ELECTROCARDIOLOGY	0.265760	10,876	2,890	69.00
69.01	CARDIAC REHAB	1.189004	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157406	67,707	10,657	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.400198	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.312912	236,260	73,929	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
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	0.638554	458	292	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2.030701	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
95.00	AMBULANCE SERVICES				95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		656,321	244,177	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)		656,321		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 3/20/2012 4:57 pm
		Title XVII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,294,059	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		8,294,059	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		8,377,000	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		72,509	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,375,005	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)		4,929,486	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)		4,929,486	30.00
31.00	Primary payer payments		41	31.00
32.00	Subtotal (line 30 minus line 31)		4,929,445	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		469,493	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		469,493	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		441,329	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		5,398,938	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)		5,398,938	40.00
41.00	Interim payments		5,279,354	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)		119,584	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		112,793	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet E
Part B
Date/Time Prepared:
3/20/2012 4:57 pm

Title XVIII

Hospital

Cost

Overrides

1.00

WORKSHEET OVERRIDE VALUES

112.00 Override of Ancillary service charges (line 12)

0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet E-1
Part I
Date/Time Prepared:
3/20/2012 4:57 pm

		Title XVIII		Hospital		Cost	
		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		3,507,772		3,999,487	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	04/15/2011	147,320	04/15/2011	12,676	3.01	
3.02		09/23/2011	748,182	09/23/2011	1,267,191	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)		895,502		1,279,867	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)		4,403,274		5,279,354	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		366,490		119,584	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		4,769,764		5,398,938	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141322

Period:

Worksheet E-1

Component CCN: 14Z322

From 10/01/2010
To 09/30/2011

Part I
Date/Time Prepared:
3/20/2012 4:57 pm

Title XVIII

Swing Beds - SNF

Cost

		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		1,148,195		0	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	04/15/2011	28,992		0	3.01
3.02		09/23/2011	129,380		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)		158,372		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)		1,306,567		0	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		190,270		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,496,837		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet E-2
		Component CCN: 14Z322	Date/Time Prepared: 3/20/2012 4:57 pm	
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,257,504	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	246,619	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	639	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,504,123	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,504,123	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,504,123	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,286	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,496,837	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	1,496,837	0	19.00
20.00	Interim payments	1,306,567	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	190,270	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2	20,282	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141322	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part V Date/Time Prepared: 3/20/2012 4:57 pm
		Title XVII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		5,084,395	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		5,084,395	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)		5,135,239	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		5,135,239	19.00
20.00	Deductibles (exclude professional component)		436,419	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		4,698,820	22.00
23.00	Coinurance		566	23.00
24.00	Subtotal (line 22 minus line 23)		4,698,254	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		71,510	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		71,510	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		65,703	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)		4,769,764	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		4,769,764	30.00
31.00	Interim payments		4,403,274	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		366,490	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		69,229	34.00

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

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet G

Date/Time Prepared:
3/20/2012 4:57 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	148,417	0	0	0	1.00
2.00	Temporary investments	6,050,939	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,366,154	0	0	0	4.00
5.00	Other receivable	294,650	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,213,116	0	0	0	6.00
7.00	Inventory	438,825	0	0	0	7.00
8.00	Prepaid expenses	189,698	0	0	0	8.00
9.00	Other current assets	1,147,428	0	0	0	9.00
10.00	Due from other funds	1,783,141	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,206,136	0	0	0	11.00
FIXED ASSETS						
12.00	Land	936,822	0	0	0	12.00
13.00	Land improvements	5,784,294	0	0	0	13.00
14.00	Accumulated depreciation	-326,344	0	0	0	14.00
15.00	Buildings	41,759,963	0	0	0	15.00
16.00	Accumulated depreciation	-1,930,270	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	12,830,230	0	0	0	23.00
24.00	Accumulated depreciation	-5,838,674	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)	53,216,021	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	9,000,470	0	0	0	31.00
32.00	Deposits on leases	103,233	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,005,526	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,109,229	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	78,531,386	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	915,142	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,031,970	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,398,429	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	794,197	0	0	0	43.00
44.00	Other current liabilities	463,819	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,603,557	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	42,478,576	0	0	0	47.00
48.00	Unsecured loans	103,233	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	42,581,809	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	47,185,366	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	31,346,020				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	31,346,020	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	78,531,386	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-1

Date/Time Prepared:
3/20/2012 4:57 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		31,238,327		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		107,693			2.00
3.00	Total (sum of line 1 and line 2)		31,346,020		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		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)		31,346,020		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		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)		31,346,020		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-1

Date/Time Prepared:
3/20/2012 4:57 pm

		Endowment Fund		Plant Fund			
		5.00	6.00	7.00	8.00		
		1.00	Fund balances at beginning of period		0		
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) (specify)	0		0		4.00	
5.00		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) (specify)	0		0		12.00	
13.00		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: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-2 Parts

Date/Time Prepared:
3/20/2012 4:57 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,857,848		2,857,848	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	287,550		287,550	5.00
6.00	Swing bed - NF	50,400		50,400	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,195,798		3,195,798	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,195,798		3,195,798	17.00
18.00	Ancillary services	10,316,951	54,446,068	64,763,019	18.00
19.00	Outpatient services	0	37,635	37,635	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				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	26.00
27.00	NURSERY	295,962	0	295,962	27.00
27.01	PROFESSIONAL FEES	300,406	5,657,033	5,957,439	27.01
27.02	CARE A VAN	0	95,022	95,022	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,109,117	60,235,758	74,344,875	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		35,930,335		29.00
30.00	PROVISION FOR BAD DEBTS	1,547,119			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)		1,547,119		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)		37,477,454		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141322

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-3

Date/Time Prepared:
3/20/2012 4:57 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	74,344,875	1.00
2.00	Less contractual allowances and discounts on patients' accounts	38,399,645	2.00
3.00	Net patient revenues (line 1 minus line 2)	35,945,230	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	37,477,454	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,532,224	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	123,618	6.00
7.00	Income from investments	196,866	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	0	10.00
11.00	Rebates and refunds of expenses	41,534	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	89,087	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	9,278	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	120,572	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	180,337	24.00
24.01	MANAGEMENT SUPPORT	14,040	24.01
24.02	MEDI CAID ACCESS IMPROVEMENT PAYMENTS	2,643,079	24.02
24.03	SALE OF REFUSE & JUNK	21,704	24.03
25.00	Total other income (sum of lines 6-24)	3,440,115	25.00
26.00	Total (line 5 plus line 25)	1,907,891	26.00
27.00	OTHER NONOPERATING EXPENSES	1,515,755	27.00
27.01	LOSS ON DISPOSAL OF ASSETS	95,312	27.01
27.02	UNREALIZED LOSS ON INVESTMENTS	18,191	27.02
27.03	CONTRIBUTIONS	170,940	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	1,800,198	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	107,693	29.00