

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).  
 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY  
 Provider CCN: 144013  
 Period: From 05/01/2010 To 04/30/2011  
 FORM APPROVED OMB NO. 0938-0050  
 Worksheet 5  
 Parts I-III  
 Date/Time Prepared: 11/8/2011 1:52 pm

**PART I - COST REPORT STATUS**

Provider use only	1. <input type="checkbox"/> Electronically filed cost report	Date:	Time:
	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.		
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: 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 LINCOLN PRAIRIE for the cost reporting period beginning 05/01/2010 and ending 04/30/2011 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.

(Signed) *Sam J. Pitt*  
 Officer or Administrator of Provider(s)  
 Title Sr VP / CFO  
 Date 11-17-11

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	0	0	0	-4,199,117	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 Skilled Nursing Facility	0	0	0	0	0	7.00
8.00 Nursing Facility	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	0	0	0	-4,199,117	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: 144013		Period: From 05/01/2010 To 04/30/2011		Worksheet S-2 Part I Date/Time Prepared: 11/8/2011 12:52 pm					
1.00		2.00		3.00		4.00							
<b>Hospital and Hospital Health Care Complex Address:</b>													
1.00	Street: 5230 S 6TH ST.			PO Box:				1.00					
2.00	City: SPRINGFIELD			State: IL		Zip Code: 62703		County: SANGAMON					
<b>Hospital and Hospital-Based Component Identification:</b>													
	Component Name			CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
								V	XVIII	XIX			
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00					
3.00	Hospital			LINCOLN PRAIRIE	144013	44100	4	05/15/2008	N	N	O	3.00	
4.00	Subprovider - IPF											4.00	
5.00	Subprovider - IRF											5.00	
6.00	Subprovider - (Other)											6.00	
7.00	Swing Beds - SNF								N	N	N	7.00	
8.00	Swing Beds - NF								N		N	8.00	
9.00	Hospital-Based SNF											9.00	
10.00	Hospital-Based NF											10.00	
11.00	Hospital-Based OLTC											11.00	
12.00	Hospital-Based HHA											12.00	
13.00	Separately Certified ASC											13.00	
14.00	Hospital-Based Hospice											14.00	
15.00	Hospital-Based Health Clinic - RHC											15.00	
16.00	Hospital-Based Health Clinic - FQHC											16.00	
17.00	Hospital-Based (CMHC) 1								N	N	N	17.00	
17.10	Hospital-Based (CORF) 1								N	N	N	17.10	
18.00	Renal Dialysis											18.00	
19.00	Other											19.00	
							From:	To:					
							1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2010	04/30/2011		20.00			
21.00	Type of Control (see instructions)						4				21.00		
<b>Inpatient PPS Information</b>													
22.00	Does this facility qualify for and receive disproportionate share hospital payment in accordance with 42 CFR Section §412.106, or low income payment in accordance with 42 CFR Section §412.624(e)(2)? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		N		23.00		
				In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days				
				1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If line 22 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.						0	0	0	0	0	0	24.00
25.00	If line 22 is "yes", and this provider is an IRF then enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid 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	25.00
							1.00						
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.										1	26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.										1	27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.										0	35.00	
							Beginning:	Ending:					
							1.00	2.00					
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.											36.00	
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144013	Period: From 05/01/2010 To 04/30/2011	Worksheet S-2 Part I Date/Time Prepared: 11/8/2011 12:52 pm		
		V	XVIII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	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	
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00		62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		0.00		62.01	
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	<b>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.</b> 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
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
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
<b>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</b>						
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
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y				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)	N	N	0		71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00
				1.00		
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.				N	80.00
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	86.00
				V	XIX	
				1.00	2.00	
<b>Title V or XIX Inpatient Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.	N		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

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		V 1.00	XIX 2.00		
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		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.				109.00
				1.00	2.00
<b>Miscellaneous Cost Reporting Information</b>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N		115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		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.		0	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.		0	119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00	
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00	
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00	
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	
<b>All Providers</b>					
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	399001	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: UNIVERSAL HEALTH SERVICES	Contractor's Name: 399001		Contractor's Number: 399001	141.00
142.00	Street: 367 SOUTH GULPH ROAD	PO Box: P.O. BOX			142.00
143.00	City: KING OF PRUSSIA	State: 44	Zip Code: 19406		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	

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		1.00			2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
147.00	was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	was the 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			
<b>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)</b>							
155.00	Hospital	N			N	155.00	
156.00	Subprovider - IPF	N			N	156.00	
157.00	Subprovider - IRF	N			N	157.00	
158.00	Subprovider - Other	N			N	158.00	
159.00	SNF	N			N	159.00	
160.00	HHA	N			N	160.00	
161.00	CMHC				N	161.00	
						1.00	
<b>Multicampus</b>							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
						1.00	
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>							
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)						0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00169.00

Health Financial Systems

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 144013	Period: From 05/01/2010 To 04/30/2011	Worksheet S-2 Part II Date/Time Prepared: 11/8/2011 12:52 pm
			Y/N 1.00	Date 2.00
<b>General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.</b>				
<b>COMPLETED BY ALL HOSPITALS</b>				
<b>Provider Organization and Operation</b>				
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 1.00	Date 2.00	V/I 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)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
<b>Financial Data and Reports</b>				
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 1.00	Legal Oper. 2.00
<b>Approved Educational Activities</b>				
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	
<b>Bad Debts</b>				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			N 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.			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			14.00
<b>Bed Complement</b>				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N 15.00
		<b>Part A</b>		
		Description	Y/N	Date
		0	1.00	2.00
<b>PS&amp;R Data</b>				
16.00	was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		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.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for other? Describe the other adjustments:			20.00

		Part A		
Description		Y/N	Date	
0		1.00	2.00	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	Y		21.00
				1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>				
<b>Capital Related Cost</b>				
22.00	Have assets been 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
<b>Interest Expense</b>				
28.00	were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
<b>Purchased Services</b>				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
<b>Provider-Based Physicians</b>				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	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.	Y		35.00
		Y/N	Date	
		1.00	2.00	
<b>Home Office Costs</b>				
36.00	were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2010	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet S-2  
Part II  
Date/Time Prepared:  
11/8/2011 12:52 pm

		Part B		
		Y/N	Date	
		3.00	4.00	
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		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.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	Y		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/8/2011 12:52 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	
	Line Number				
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	88	32,720	0.00	1.00
2.00 HMO					2.00
3.00 HMO IPF					3.00
4.00 HMO IRF					4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		88	32,720	0.00	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)		88	32,720	0.00	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	46.00	0	0		21.00
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC	99.00				25.00
25.10 CMHC - CORF	99.10				25.10
26.00 RURAL HEALTH CLINIC					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		88			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

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	0	14,156	17,918		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	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	0	14,156	17,918		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	0	14,156	17,918		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				0		21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC	0	0	0	0		25.00
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	0		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/8/2011 12:52 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	0	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)	0.00	113.00	0.00	0	0	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	0.00	0.00	0.00			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	0.00	0.00	0.00			25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	113.00	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: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/8/2011 12:52 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)	1,057	1,381	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)	1,057	1,381	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		0	21.00
22.00 HOME HEALTH AGENCY			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)			23.00
24.00 HOSPICE			24.00
25.00 CMHC - CMHC			25.00
25.10 CMHC - CORF			25.10
26.00 RURAL HEALTH CLINIC			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER			26.25
27.00 Total (sum of lines 14-26)			27.00
28.00 Observation Bed Days			28.00
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: 144013

Period:  
From 05/01/2010  
To 04/30/2011

worksheet 5-10

Date/Time Prepared:  
11/8/2011 12:52 pm

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
					1.00
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)			0.403125	1.00
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid			0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			0	6.00
7.00	Medicaid cost (line 1 times line 6)			0	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 2 plus line 5 minus line 7)			0	8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone SCHIP			0	9.00
10.00	Stand-alone SCHIP charges			0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 9 minus line 11)			0	12.00
<b>Other state or local government indigent care program (see instructions for each line)</b>					
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 13 minus line 15)			0	16.00
<b>Uncompensated care (see instructions for each line)</b>					
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)			0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1.00	2.00	3.00	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	0	0	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?				24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit				25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			0	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			0	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			0	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			0	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			0	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet A

Date/Time Prepared:  
11/8/2011 12:52 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00		1,584,622	1,584,622	208,597	1,793,219	1.00
2.00		195,025	195,025	20,065	215,090	2.00
3.00		208,597	208,597	-208,597	0	3.00
4.00	86,735	865,935	952,670	0	952,670	4.00
5.00	1,564,929	3,654,257	5,219,186	-263,585	4,955,601	5.00
7.00	110,750	558,037	668,787	0	668,787	7.00
8.00	0	117,809	117,809	24,586	142,395	8.00
9.00	0	206,269	206,269	-24,586	181,683	9.00
10.00	119,377	290,377	409,754	-400	409,354	10.00
11.00	0	0	0	0	0	11.00
13.00	395,206	27,391	422,597	0	422,597	13.00
16.00	52,811	64,430	117,241	48,320	165,561	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	3,402,899	319,075	3,721,974	0	3,721,974	30.00
46.00	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00	0	0	0	0	0	54.00
60.00	0	109,041	109,041	0	109,041	60.00
67.00	0	0	0	0	0	67.00
68.00	0	0	0	0	0	68.00
69.00	0	0	0	0	0	69.00
70.00	0	0	0	0	0	70.00
71.00	0	0	0	0	0	71.00
73.00	174,224	218,854	393,078	0	393,078	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	307,101	22,159	329,260	0	329,260	90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00	0	0	0	0	0	99.00
99.10	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	6,214,032	8,441,878	14,655,910	-195,600	14,460,310	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	0	0	0	0	0	190.00
191.00	0	0	0	0	0	191.00
192.00	0	0	0	0	0	192.00
193.00	0	0	0	0	0	193.00
194.00	0	0	0	0	0	194.00
194.01	72,498	5,746	78,244	0	78,244	194.01
194.02	0	0	0	195,600	195,600	194.02
200.00	6,286,530	8,447,624	14,734,154	0	14,734,154	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet A

Date/Time Prepared:  
11/8/2011 12:52 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	CAP REL COSTS-BLDG & FIXT	-1,385,796	407,423	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-12,414	202,676	2.00
3.00	OTHER CAP REL COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	-131,385	821,285	4.00
5.00	ADMINISTRATIVE & GENERAL	-2,486,361	2,469,240	5.00
7.00	OPERATION OF PLANT	-3,150	665,637	7.00
8.00	LAUNDRY & LINEN SERVICE	0	142,395	8.00
9.00	HOUSEKEEPING	0	181,683	9.00
10.00	DIETARY	-22,220	387,134	10.00
11.00	CAFETERIA	0	0	11.00
13.00	NURSING ADMINISTRATION	0	422,597	13.00
16.00	MEDICAL RECORDS & LIBRARY	-6,129	159,432	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	-19,794	3,702,180	30.00
46.00	OTHER LONG TERM CARE	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	LABORATORY	0	109,041	60.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	393,078	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	CLINIC	-4,190	325,070	90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.00	CMHC	0	0	99.00
99.10	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-4,071,439	10,388,871	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	RESEARCH	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	NONPAID WORKERS	0	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	EDUCATION	0	78,244	194.01
194.02	COMMUNITY RELATIONS	0	195,600	194.02
200.00	TOTAL (SUM OF LINES 118-199)	-4,071,439	10,662,715	200.00

Health Financial Systems  
RECLASSIFICATIONS

In Lieu of Form CMS-2552-10

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

worksheet A-6  
Date/Time Prepared:  
11/8/2011 12:52 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - RENT</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	20,065	1.00
2.00		0.00	0	0	2.00
TOTALS			0	20,065	
<b>B - COMMUNITY RELATIONS</b>					
1.00	COMMUNITY RELATIONS	194.02	153,022	42,578	1.00
TOTALS			153,022	42,578	
<b>C - WTB CODING</b>					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	24,586	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	48,320	2.00
TOTALS			0	72,906	
<b>D - CAPITAL</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	48,282	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	160,315	2.00
TOTALS			0	208,597	
500.00	Grand Total: Increases		153,022	344,146	500.00

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet A-6  
Date/Time Prepared:  
11/8/2011 12:52 pm

		Decreases					
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - RENT</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	19,665	10		1.00
2.00	DIETARY	10.00	0	400	0		2.00
	TOTALS		0	20,065			
<b>B - COMMUNITY RELATIONS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	153,022	42,578	0		1.00
	TOTALS		153,022	42,578			
<b>C - WTB CODING</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	48,320	0		1.00
2.00	HOUSEKEEPING	9.00	0	24,586	0		2.00
	TOTALS		0	72,906			
<b>D - CAPITAL</b>							
1.00	OTHER CAP REL COSTS	3.00	0	48,282	12		1.00
2.00	OTHER CAP REL COSTS	3.00	0	160,315	13		2.00
	TOTALS		0	208,597			
500.00	Grand Total: Decreases		153,022	344,146			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
11/8/2011 12:52 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	3,203,487	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	13,707,331	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	1,190,373	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,101,191	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	18,101,191	0	0	0	10.00
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)
		9.00	10.00	11.00	12.00	13.00
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	CAP REL COSTS-BLDG & FIXT	589,290	0	995,332	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	191,517	0	3,508	0	2.00
3.00	Total (sum of lines 1-2)	780,807	0	998,840	0	3.00
<b>COMPUTATION OF RATIOS</b>						
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
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
11/8/2011 12:52 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	3,203,487	0		1.00		
2.00	Land Improvements	0	0		2.00		
3.00	Buildings and Fixtures	13,707,331	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	1,190,373	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	18,101,191	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	18,101,191	0		10.00		
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,584,622		1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	195,025		2.00		
3.00	Total (sum of lines 1-2)	0	1,779,647		3.00		
<b>ALLOCATION OF OTHER CAPITAL</b>							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	198,826	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	179,103	20,065	2.00
3.00	Total (sum of lines 1-2)	0	0	0	377,929	20,065	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
11/8/2011 12:52 pm

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	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	48,282	160,315	0	407,423	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,508	0	0	0	202,676	2.00
3.00	Total (sum of lines 1-2)	3,508	48,282	160,315	0	610,099	3.00

		Expense Classification on worksheet A To/From Which the Amount is to be Adjusted			
		Basis/Code (2)	Amount	Cost Center	Line #
		1.00	2.00	3.00	4.00
1.00	Investment income - buildings and fixtures (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - movable equipment (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00	Investment income - other (chapter 2)		0		0.00 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		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)		0		0.00 8.00
9.00	Parking lot (chapter 21)		0		0.00 9.00
10.00	Provider-based physician adjustment	A-8-2	-1,002,009		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	-902,001		12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests	B	-22,220	DIETARY	10.00 14.00
15.00	Rental of quarters to employee and others		0		0.00 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients		0		0.00 17.00
18.00	Sale of medical records and abstracts	B	-6,129	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	*** Cost Center Deleted ***	65.00 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	66.00 24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00	Depreciation - buildings and fixtures	A	-390,464	CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - movable equipment	A	-12,414	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	OTHER REVENUE	B	-62,546	ADMINISTRATIVE & GENERAL	5.00 33.00
34.00	MEDICAL INSURANCE	A	-48,751	EMPLOYEE BENEFITS	4.00 34.00
35.00	LIABILITY INSURANCE	A	-27,511	ADMINISTRATIVE & GENERAL	5.00 35.00
36.00	WORKERS COMP INSURANCE	A	-79,366	EMPLOYEE BENEFITS	4.00 36.00
37.00	MARKETING	A	-41,254	ADMINISTRATIVE & GENERAL	5.00 37.00
38.00	LOBBYING	A	-15,517	ADMINISTRATIVE & GENERAL	5.00 38.00
39.00	BAD DEBTS	A	-38,423	ADMINISTRATIVE & GENERAL	5.00 39.00
40.00	PROVIDER TAX	A	-1,360,429	ADMINISTRATIVE & GENERAL	5.00 40.00
41.00	MISCELLANEOUS	A	-59,507	ADMINISTRATIVE & GENERAL	5.00 41.00
42.00	MISCELLANEOUS	A	-3,268	EMPLOYEE BENEFITS	4.00 42.00
43.00	MISCELLANEOUS	A	370	CLINIC	90.00 43.00
44.00			0		0.00 44.00
45.00			0		0.00 45.00
46.00			0		0.00 46.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-4,071,439		50.00

	wkst. A-7 Ref.	
	5.00	
1.00 Investment income - buildings and fixtures (chapter 2)	0	1.00
2.00 Investment income - movable equipment (chapter 2)	0	2.00
3.00 Investment income - other (chapter 2)	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00 Television and radio service (chapter 21)	0	8.00
9.00 Parking lot (chapter 21)	0	9.00
10.00 Provider-based physician adjustment	0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00 Related organization transactions (chapter 10)	0	12.00
13.00 Laundry and linen service	0	13.00
14.00 Cafeteria-employees and guests	0	14.00
15.00 Rental of quarters to employee and others	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	0	16.00
17.00 Sale of drugs to other than patients	0	17.00
18.00 Sale of medical records and abstracts	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)	0	19.00
20.00 vending machines	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		25.00
26.00 Depreciation - buildings and fixtures	9	26.00
27.00 Depreciation - movable equipment	9	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 OTHER REVENUE	0	33.00
34.00 MEDICAL INSURANCE	0	34.00
35.00 LIABILITY INSURANCE	0	35.00
36.00 WORKERS COMP INSURANCE	0	36.00
37.00 MARKETING	0	37.00
38.00 LOBBYING	0	38.00
39.00 BAD DEBTS	0	39.00
40.00 PROVIDER TAX	0	40.00
41.00 MISCELLANEOUS	0	41.00
42.00 MISCELLANEOUS	0	42.00
43.00 MISCELLANEOUS	0	43.00
44.00	0	44.00
45.00	0	45.00
46.00	0	46.00
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: 144013

Period:  
From 05/01/2010  
To 04/30/2011

worksheet A-8-1

Date/Time Prepared:  
11/8/2011 12:52 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	INTERCO INTEREST	2.00
3.00	0.00			3.00
4.00	0.00			4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			5.00

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

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>				

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

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

6.00	B	UNIVERSAL HEALT	100.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			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: 144013  
 Period: From 05/01/2010 To 04/30/2011  
 Worksheet A-8-1  
 Date/Time Prepared: 11/8/2011 12:52 pm

	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	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	484,940	391,609	93,331	0	1.00
2.00	0	995,332	-995,332	11	2.00
3.00	0	0	0	0	3.00
4.00	0	0	0	0	4.00
5.00	484,940	1,386,941	-902,001		5.00
TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.					

\* 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	
	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	UNIVERSAL HEALT	100.00	HEALTH CARE	6.00
7.00		0.00		7.00
8.00		0.00		8.00
9.00		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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet A-8-2  
Date/Time Prepared:  
11/8/2011 12:52 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	5.00	AGGREGATE	974,505	974,505	1.00
2.00	7.00	AGGREGATE	3,150	3,150	2.00
3.00	30.00	AGGREGATE	19,794	19,794	3.00
4.00	90.00	AGGREGATE	4,560	4,560	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (lines 1.00 through 199.00)	1,002,009	1,002,009	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet A-8-2

Date/Time Prepared:  
11/8/2011 12:52 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	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: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet A-8-2

Date/Time Prepared:  
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	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
	12.00	13.00	14.00	15.00	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 CCN: 144013

Period:  
 From 05/01/2010  
 To 04/30/2011

Worksheet A-8-2  
 Date/Time Prepared:  
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	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	974,505	1.00
2.00	0	3,150	2.00
3.00	0	19,794	3.00
4.00	0	4,560	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	0	0	10.00
200.00	0	1,002,009	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

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			
		1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT	407,423	407,423			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	202,676		202,676		2.00
4.00	EMPLOYEE BENEFITS	821,285	1,643	817	823,745	4.00
5.00	ADMINISTRATIVE & GENERAL	2,469,240	39,066	19,434	187,594	2,715,334 5.00
7.00	OPERATION OF PLANT	665,637	90,118	44,830	14,715	815,300 7.00
8.00	LAUNDRY & LINEN SERVICE	142,395	0	0	0	142,395 8.00
9.00	HOUSEKEEPING	181,683	2,624	1,305	0	185,612 9.00
10.00	DIETARY	387,134	14,632	7,279	15,861	424,906 10.00
11.00	CAFETERIA	0	0	0	0	0 11.00
13.00	NURSING ADMINISTRATION	422,597	2,090	1,040	52,509	478,236 13.00
16.00	MEDICAL RECORDS & LIBRARY	159,432	3,006	1,496	7,017	170,951 16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	3,702,180	241,041	119,907	452,134	4,515,262 30.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0 46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	LABORATORY	109,041	0	0	0	109,041 60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
73.00	DRUGS CHARGED TO PATIENTS	393,078	1,630	811	23,148	418,667 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	CLINIC	325,070	9,092	4,523	40,803	379,488 90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00	CMHC	0	0	0	0	0 99.00
99.10	CORF	0	0	0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,388,871	404,942	201,442	793,781	10,355,192 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191.00	RESEARCH	0	0	0	0	0 191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
193.00	NONPAID WORKERS	0	0	0	0	0 193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01	EDUCATION	78,244	1,333	663	9,633	89,873 194.01
194.02	COMMUNITY RELATIONS	195,600	1,148	571	20,331	217,650 194.02
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)	10,662,715	407,423	202,676	823,745	10,662,715 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet B  
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	2,715,334					5.00
7.00	OPERATION OF PLANT	278,559	1,093,859				7.00
8.00	LAUNDRY & LINEN SERVICE	48,651	0	191,046			8.00
9.00	HOUSEKEEPING	63,417	10,376	0	259,405		9.00
10.00	DIETARY	145,175	57,865	0	13,854	641,800	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	163,396	8,266	0	1,979	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	58,408	11,889	0	2,847	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	1,542,704	953,246	191,046	228,224	641,800	30.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	37,255	0	0	0	0	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	143,043	6,446	0	1,543	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	129,657	35,957	0	8,609	0	90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,610,265	1,084,045	191,046	257,056	641,800	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	EDUCATION	30,706	5,273	0	1,262	0	194.01
194.02	COMMUNITY RELATIONS	74,363	4,541	0	1,087	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,715,334	1,093,859	191,046	259,405	641,800	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	0					11.00
13.00	NURSING ADMINISTRATION	0	651,877				13.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	244,095			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	0	651,877	222,025	8,946,184	0	30.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	1,374	147,670	0	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	13,880	583,579	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	6,816	560,527	0	90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	651,877	244,095	10,237,960	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	EDUCATION	0	0	0	127,114	0	194.01
194.02	COMMUNITY RELATIONS	0	0	0	297,641	0	194.02
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)	0	651,877	244,095	10,662,715	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet B  
Part I  
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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	CAP REL COSTS-BLDG & FIXT		1.00
2.00	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
8.00	LAUNDRY & LINEN SERVICE		8.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
13.00	NURSING ADMINISTRATION		13.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	ADULTS & PEDIATRICS	8,946,184	30.00
46.00	OTHER LONG TERM CARE	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	LABORATORY	147,670	60.00
67.00	OCCUPATIONAL THERAPY	0	67.00
68.00	SPEECH PATHOLOGY	0	68.00
69.00	ELECTROCARDIOLOGY	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	583,579	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	CLINIC	560,527	90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.00	CMHC	0	99.00
99.10	CORF	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,237,960	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	RESEARCH	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	NONPAID WORKERS	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	EDUCATION	127,114	194.01
194.02	COMMUNITY RELATIONS	297,641	194.02
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	10,662,715	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet B  
Part II  
Date/Time Prepared:  
11/8/2011 12:52 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00						1.00
2.00						2.00
4.00	0	1,643	817	2,460	2,460	4.00
5.00	36,496	39,066	19,434	94,996	561	5.00
7.00	0	90,118	44,830	134,948	44	7.00
8.00	0	0	0	0	0	8.00
9.00	0	2,624	1,305	3,929	0	9.00
10.00	0	14,632	7,279	21,911	47	10.00
11.00	0	0	0	0	0	11.00
13.00	0	2,090	1,040	3,130	157	13.00
16.00	0	3,006	1,496	4,502	21	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	0	241,041	119,907	360,948	1,349	30.00
46.00	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00	0	0	0	0	0	54.00
60.00	0	0	0	0	0	60.00
67.00	0	0	0	0	0	67.00
68.00	0	0	0	0	0	68.00
69.00	0	0	0	0	0	69.00
70.00	0	0	0	0	0	70.00
71.00	0	0	0	0	0	71.00
73.00	0	1,630	811	2,441	69	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	0	9,092	4,523	13,615	122	90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00	0	0	0	0	0	99.00
99.10	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	36,496	404,942	201,442	642,880	2,370	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	0	0	0	0	0	190.00
191.00	0	0	0	0	0	191.00
192.00	0	0	0	0	0	192.00
193.00	0	0	0	0	0	193.00
194.00	0	0	0	0	0	194.00
194.01	0	1,333	663	1,996	29	194.01
194.02	0	1,148	571	1,719	61	194.02
200.00				0		200.00
201.00		0	0	0	0	201.00
202.00	36,496	407,423	202,676	646,595	2,460	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet B  
Part II  
Date/Time Prepared:  
11/8/2011 12:52 pm

Cost Center Description	ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL	95,557					5.00
7.00 OPERATION OF PLANT	9,803	144,795				7.00
8.00 LAUNDRY & LINEN SERVICE	1,712	0	1,712			8.00
9.00 HOUSEKEEPING	2,232	1,373	0	7,534		9.00
10.00 DIETARY	5,109	7,660	0	402	35,129	10.00
11.00 CAFETERIA	0	0	0	0	0	11.00
13.00 NURSING ADMINISTRATION	5,750	1,094	0	57	0	13.00
16.00 MEDICAL RECORDS & LIBRARY	2,056	1,574	0	83	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	54,289	126,182	1,712	6,628	35,129	30.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 LABORATORY	1,311	0	0	0	0	60.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00 DRUGS CHARGED TO PATIENTS	5,034	853	0	45	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	4,563	4,760	0	250	0	90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	91,859	143,496	1,712	7,465	35,129	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 EDUCATION	1,081	698	0	37	0	194.01
194.02 COMMUNITY RELATIONS	2,617	601	0	32	0	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	95,557	144,795	1,712	7,534	35,129	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet B  
Part II  
Date/Time Prepared:  
11/8/2011 12:52 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	11.00	13.00	16.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00						1.00
2.00						2.00
4.00						4.00
5.00						5.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00	0					11.00
13.00	0	10,188				13.00
16.00	0	0	8,236			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	0	10,188	7,492	603,917	0	30.00
46.00	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00	0	0	0	0	0	54.00
60.00	0	0	46	1,357	0	60.00
67.00	0	0	0	0	0	67.00
68.00	0	0	0	0	0	68.00
69.00	0	0	0	0	0	69.00
70.00	0	0	0	0	0	70.00
71.00	0	0	0	0	0	71.00
73.00	0	0	468	8,910	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	0	0	230	23,540	0	90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00	0	0	0	0	0	99.00
99.10	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	0	10,188	8,236	637,724	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	0	0	0	0	0	190.00
191.00	0	0	0	0	0	191.00
192.00	0	0	0	0	0	192.00
193.00	0	0	0	0	0	193.00
194.00	0	0	0	0	0	194.00
194.01	0	0	0	3,841	0	194.01
194.02	0	0	0	5,030	0	194.02
200.00	0	0	0	0	0	200.00
201.00	0	0	0	0	0	201.00
202.00	0	10,188	8,236	646,595	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet B  
Part II  
Date/Time Prepared:  
11/8/2011 12:52 pm

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	CAP REL COSTS-BLDG & FIXT		1.00
2.00	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
8.00	LAUNDRY & LINEN SERVICE		8.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
13.00	NURSING ADMINISTRATION		13.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	ADULTS & PEDIATRICS	603,917	30.00
46.00	OTHER LONG TERM CARE	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	LABORATORY	1,357	60.00
67.00	OCCUPATIONAL THERAPY	0	67.00
68.00	SPEECH PATHOLOGY	0	68.00
69.00	ELECTROCARDIOLOGY	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	8,910	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	CLINIC	23,540	90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.00	CMHC	0	99.00
99.10	CORF	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00	SUBTOTALS (SUM OF LINES 1-117)	637,724	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	RESEARCH	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	NONPAID WORKERS	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	EDUCATION	3,841	194.01
194.02	COMMUNITY RELATIONS	5,030	194.02
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	646,595	202.00

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT	94,728				1.00
2.00	CAP REL COSTS-MVBLE EQUIP		94,728			2.00
4.00	EMPLOYEE BENEFITS	382	382	6,199,795		4.00
5.00	ADMINISTRATIVE & GENERAL	9,083	9,083	1,411,907	-2,715,334	7,947,381 5.00
7.00	OPERATION OF PLANT	20,953	20,953	110,750	0	815,300 7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	142,395 8.00
9.00	HOUSEKEEPING	610	610	0	0	185,612 9.00
10.00	DIETARY	3,402	3,402	119,377	0	424,906 10.00
11.00	CAFETERIA	0	0	0	0	0 11.00
13.00	NURSING ADMINISTRATION	486	486	395,206	0	478,236 13.00
16.00	MEDICAL RECORDS & LIBRARY	699	699	52,811	0	170,951 16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	56,043	56,043	3,402,899	0	4,515,262 30.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0 46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	LABORATORY	0	0	0	0	109,041 60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
73.00	DRUGS CHARGED TO PATIENTS	379	379	174,224	0	418,667 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	CLINIC	2,114	2,114	307,101	0	379,488 90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00	CMHC	0	0	0	0	0 99.00
99.10	CORF	0	0	0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	94,151	94,151	5,974,275	-2,715,334	7,639,858 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191.00	RESEARCH	0	0	0	0	0 191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
193.00	NONPAID WORKERS	0	0	0	0	0 193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01	EDUCATION	310	310	72,498	0	89,873 194.01
194.02	COMMUNITY RELATIONS	267	267	153,022	0	217,650 194.02
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)	407,423	202,676	823,745		2,715,334 202.00
203.00	Unit cost multiplier (wkst. B, Part I)	4.300978	2.139557	0.132866		0.341664 203.00
204.00	Cost to be allocated (per wkst. B, Part II)			2,460		95,557 204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000397		0.012024 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet B-1

Date/Time Prepared:  
11/8/2011 12:52 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT	64,310					7.00
8.00	LAUNDRY & LINEN SERVICE	0	17,918				8.00
9.00	HOUSEKEEPING	610	0	63,700			9.00
10.00	DIETARY	3,402	0	3,402	17,918		10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	486	0	486	0	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	699	0	699	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	56,043	17,918	56,043	17,918	0	30.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	379	0	379	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	2,114	0	2,114	0	0	90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	63,733	17,918	63,123	17,918	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	EDUCATION	310	0	310	0	0	194.01
194.02	COMMUNITY RELATIONS	267	0	267	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,093,859	191,046	259,405	641,800	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	17.009159	10.662239	4.072292	35.818730	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	144,795	1,712	7,534	35,129	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.251516	0.095546	0.118273	1.960542	0.000000	205.00

Cost Center Description	NURSING	MEDICAL	
	ADMINISTRATION	RECORDS &	
	(PT DAYS)	LIBRARY	
	13.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00			1.00
2.00			2.00
4.00			4.00
5.00			5.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
11.00			11.00
13.00	17,918		13.00
16.00	0	25,396,476	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	17,918	23,100,155	30.00
46.00	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	0	0	54.00
60.00	0	142,939	60.00
67.00	0	0	67.00
68.00	0	0	68.00
69.00	0	0	69.00
70.00	0	0	70.00
71.00	0	0	71.00
73.00	0	1,444,219	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	0	709,163	90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.00	0	0	99.00
99.10	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00	17,918	25,396,476	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	0	0	190.00
191.00	0	0	191.00
192.00	0	0	192.00
193.00	0	0	193.00
194.00	0	0	194.00
194.01	0	0	194.01
194.02	0	0	194.02
200.00			200.00
201.00			201.00
202.00	651,877	244,095	202.00
203.00	36,381,125	0.009611	203.00
204.00	10,188	8,236	204.00
205.00	0.568590	0.000324	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet C  
Part I  
Date/Time Prepared:  
11/8/2011 12:52 pm

Title XVIII

Hospital

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
			Total Costs	RCE Disallowance		
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	8,946,184		8,946,184	0	0	30.00
46.00 OTHER LONG TERM CARE	0		0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00
60.00 LABORATORY	147,670		147,670	0	0	60.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
73.00 DRUGS CHARGED TO PATIENTS	583,579		583,579	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	560,527		560,527	0	0	90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 CMHC	0		0		0	99.00
99.10 CORF	0		0		0	99.10
200.00 Subtotal (see instructions)	10,237,960	0	10,237,960	0	0	200.00
201.00 Less Observation Beds	0		0		0	201.00
202.00 Total (see instructions)	10,237,960	0	10,237,960	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet C  
Part I  
Date/Time Prepared:  
11/8/2011 12:52 pm

		Title XVIII			Hospital		
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	23,100,155		23,100,155			30.00
46.00	OTHER LONG TERM CARE	0		0			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	LABORATORY	142,939	0	142,939	1.033098	0.000000	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
73.00	DRUGS CHARGED TO PATIENTS	1,444,219	0	1,444,219	0.404079	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	709,163	709,163	0.790406	0.000000	90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	CMHC	0	0	0			99.00
99.10	CORF	0	0	0			99.10
200.00	Subtotal (see instructions)	24,687,313	709,163	25,396,476			200.00
201.00	Less observation Beds						201.00
202.00	Total (see instructions)	24,687,313	709,163	25,396,476			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 144013	Period: From 05/01/2010 To 04/30/2011	Worksheet C Part I Date/Time Prepared: 11/8/2011 12:52 pm
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Cost Center Description		PPS Inpatient Ratio	
		11.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	ADULTS & PEDIATRICS		30.00
46.00	OTHER LONG TERM CARE		46.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	LABORATORY	0.000000	60.00
67.00	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	SPEECH PATHOLOGY	0.000000	68.00
69.00	ELECTROCARDIOLOGY	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	CLINIC	0.000000	90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.00	CMHC		99.00
99.10	CORF		99.10
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet C  
Part I  
Date/Time Prepared:  
11/8/2011 12:52 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		Total Costs
				RCE Disallowance		
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	8,946,184		8,946,184	0	0 30.00
46.00	OTHER LONG TERM CARE	0		0	0	0 46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00	RADIOLOGY-DIAGNOSTIC	0		0	0	0 54.00
60.00	LABORATORY	147,670		147,670	0	0 60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	ELECTROCARDIOLOGY	0		0	0	0 69.00
70.00	ELECTROENCEPHALOGRAPHY	0		0	0	0 70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0 71.00
73.00	DRUGS CHARGED TO PATIENTS	583,579		583,579	0	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	CLINIC	560,527		560,527	0	0 90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00	CMHC	0		0		0 99.00
99.10	CORF	0		0		0 99.10
200.00	Subtotal (see instructions)	10,237,960	0	10,237,960	0	0 200.00
201.00	Less Observation Beds	0		0		0 201.00
202.00	Total (see instructions)	10,237,960	0	10,237,960	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet C  
Part I  
Date/Time Prepared:  
11/8/2011 12:52 pm

Cost Center Description	Charges			Hospital	Cost	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	23,100,155		23,100,155			30.00
46.00 OTHER LONG TERM CARE	0		0			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00 LABORATORY	142,939	0	142,939	1.033098	0.000000	60.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
73.00 DRUGS CHARGED TO PATIENTS	1,444,219	0	1,444,219	0.404079	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	709,163	709,163	0.790406	0.000000	90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 CMHC	0	0	0			99.00
99.10 CORF	0	0	0			99.10
200.00 Subtotal (see instructions)	24,687,313	709,163	25,396,476			200.00
201.00 Less observation beds						201.00
202.00 Total (see instructions)	24,687,313	709,163	25,396,476			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet C  
Part I  
Date/Time Prepared:  
11/8/2011 12:52 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS				30.00
46.00	OTHER LONG TERM CARE				46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	LABORATORY	0.000000			60.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	0.000000			90.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.00	CMHC				99.00
99.10	CORF				99.10
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 144013		Period: From 05/01/2010 To 04/30/2011		Worksheet D Part I Date/Time Prepared: 11/8/2011 12:52 pm	
Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	Cost Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	603,917	0	603,917	17,918	33.70	30.00
200.00	Total (lines 30-199)	603,917		603,917	17,918		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 144013		Period: From 05/01/2010 To 04/30/2011		Worksheet D Part I Date/Time Prepared: 11/8/2011 12:52 pm		
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX	Hospital	Cost		
		6.00	7.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	ADULTS & PEDIATRICS	14,156	477,057					30.00
200.00	Total (lines 30-199)	14,156	477,057					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 144013		Period: From 05/01/2010 To 04/30/2011		Worksheet D Part II Date/Time Prepared: 11/8/2011 12:52 pm	
Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Cost Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	0	54.00
60.00	LABORATORY	1,357	142,939	0.009494	106,061	1,007	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	8,910	1,444,219	0.006169	1,265,356	7,806	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	23,540	709,163	0.033194	0	0	90.00
200.00	Total (lines 50-199)	33,807	2,296,321		1,371,417	8,813	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 144013		Period: From 05/01/2010 To 04/30/2011		Worksheet D Part III Date/Time Prepared: 11/8/2011 12:52 pm	
Cost Center Description		Title XIX			Hospital	Cost	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0 30.00	
200.00	Total (lines 30-199)	0	0	0	0	0 200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 144013		Period: From 05/01/2010 To 04/30/2011		Worksheet D Part III Date/Time Prepared: 11/8/2011 12:52 pm	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School Cost	
		6.00	7.00	8.00	9.00	11.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	17,918	0.00	14,156	0	0	30.00
200.00	Total (lines 30-199)	17,918		14,156	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 144013		Period: From 05/01/2010 To 04/30/2011		Worksheet D Part III Date/Time Prepared: 11/8/2011 12:52 pm	
Cost Center Description		PSA Adj. Allied Health Cost 12.00	PSA Adj. All Other Medical Education Cost 13.00	Title XIX	Hospital	Cost	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	0	0				30.00
200.00	Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet D  
Part IV  
Date/Time Prepared:  
11/8/2011 12:52 pm

Cost Center Description	Title XIX			Hospital		Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0	0	90.00
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: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet D  
Part IV  
Date/Time Prepared:  
11/8/2011 12:52 pm

Cost Center Description		Title XIX			Hospital		
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0.000000	0	54.00
60.00	LABORATORY	0	142,939	0.000000	0.000000	106,061	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,444,219	0.000000	0.000000	1,265,356	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	709,163	0.000000	0.000000	0	90.00
200.00	Total (lines 50-199)	0	2,296,321			1,371,417	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet D  
Part IV  
Date/Time Prepared:  
11/8/2011 12:52 pm

Cost Center Description		Title XIX			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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0	0	90.00
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: 144013	Period: From 05/01/2010 To 04/30/2011	Worksheet D Part IV Date/Time Prepared: 11/8/2011 12:52 pm
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Cost
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	LABORATORY	0	0	60.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	CLINIC	0	0	90.00
200.00	Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144013	Period: From 05/01/2010 To 04/30/2011	Worksheet D-1	
Cost Center Description		Title XIX	Hospital	Cost	
				1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>					
<b>INPATIENT DAYS</b>					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			17,918	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			17,918	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)			17,918	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			14,156	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
<b>SWING BED ADJUSTMENT</b>					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			8,946,184	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			8,946,184	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>					
28.00	General inpatient routine service charges (excluding swing-bed charges)			23,100,155	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			23,100,155	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.387278	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)			1,289.22	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)			8,946,184	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>					
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			499.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			7,067,808	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			7,067,808	41.00
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
42.00	1.00	2.00	3.00	4.00	5.00
<b>NURSERY (title V &amp; XIX only)</b>					
<b>Intensive Care Type Inpatient Hospital Units</b>					
43.00					43.00
44.00					44.00
45.00					45.00
46.00					46.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet D-1

Date/Time Prepared:  
11/8/2011 12:52 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
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)					620,875	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,688,683	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
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
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0 69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00	Total observation bed days (see instructions)						0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0 89.00
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	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet D-1

Date/Time Prepared:  
11/8/2011 12:52 pm

Cost Center Description	Title XIX			Hospital		93.00
	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	
93.00   All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 144013	Period: From 05/01/2010 To 04/30/2011	Worksheet D-3
		Title XIX	Hospital	Date/Time Prepared: 11/8/2011 12:52 pm
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS		17,951,150	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	0	0 54.00
60.00	LABORATORY	1.033098	106,061	109,571 60.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0 69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0 71.00
73.00	DRUGS CHARGED TO PATIENTS	0.404079	1,265,356	511,304 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	CLINIC	0.790406	0	0 90.00
200.00	Total (sum of lines 50-94 and 96-98)		1,371,417	620,875 200.00
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)		1,371,417	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144013	Period: From 05/01/2010 To 04/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 11/8/2011 12:52 pm
		Title XIX	Hospital	Cost
				1.00
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services		7,688,683	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (Certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		7,688,683	4.00
5.00	Inpatient primary payer payments		712,203	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		6,976,480	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges		17,951,150	8.00
9.00	Ancillary service charges		1,371,417	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		19,322,567	12.00
<b>CUSTOMARY CHRGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		19,322,567	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 7) (see instructions)		12,346,087	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 7 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (line 7)		6,976,480	21.00
<b>PROSPECTIVE PAYMENT AMOUNT</b>				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX PPS, lessor of lines 27 or 28; non-PPS enter amount from line 27		0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 through 21, plus line 29, minus line 30)		6,976,480	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		6,976,480	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		6,976,480	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		6,976,480	40.00
41.00	Interim payments		11,175,597	41.00
42.00	Balance due provider/program (line 40 minus 41)		-4,199,117	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

Health Financial Systems

In Lieu of Form CMS-2552-10

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

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

worksheet G

Date/Time Prepared:  
11/8/2011 12:52 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	-147,770	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,614,329	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	45,343	0	0	0	7.00
8.00	Prepaid expenses	219,282	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,731,184	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	3,203,487	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	13,707,331	0	0	0	15.00
16.00	Accumulated depreciation	-308,415	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	1,190,373	0	0	0	23.00
24.00	Accumulated depreciation	-84,583	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)	17,708,193	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	-20,357,116	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-20,357,116	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	-917,739	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	165,537	0	0	0	37.00
38.00	Salaries, wages, and fees payable	280,963	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	130,928	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	577,428	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	-1,389,376	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-1,389,376	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-811,948	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	-105,791	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-105,791	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	-917,739	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet G-1

Date/Time Prepared:  
11/8/2011 12:52 pm

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
	1.00				
2.00		1,481,632		0	2.00
3.00		900,142		0	3.00
4.00		2,381,774		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		0		0	10.00
11.00		2,381,774		0	11.00
12.00	2,487,565		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		2,487,565		0	18.00
19.00		-105,791		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet G-1

Date/Time Prepared:  
11/8/2011 12:52 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00			0		0	1.00
2.00						2.00
3.00			0		0	3.00
4.00				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			0		0	10.00
11.00			0		0	11.00
12.00	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			0		0	18.00
19.00			0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet G-2 Parts

Date/Time Prepared:  
11/8/2011 12:52 pm

Cost Center Description	Inpatient	Outpatient	Total	
	1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>				
<b>General Inpatient Routine Services</b>				
1.00 Hospital	23,100,155		23,100,155	1.00
2.00 SUBPROVIDER - IPF				2.00
3.00 SUBPROVIDER - IRF				3.00
4.00 SUBPROVIDER				4.00
5.00 Swing bed - SNF	0		0	5.00
6.00 Swing bed - NF	0		0	6.00
7.00 SKILLED NURSING FACILITY				7.00
8.00 NURSING FACILITY				8.00
9.00 OTHER LONG TERM CARE	0		0	9.00
10.00 Total general inpatient care services (sum of lines 1-9)	23,100,155		23,100,155	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>				
11.00 INTENSIVE CARE UNIT				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)	23,100,155		23,100,155	17.00
18.00 Ancillary services	1,587,158	0	1,587,158	18.00
19.00 Outpatient services	0	709,163	709,163	19.00
20.00 RURAL HEALTH CLINIC	0	0	0	20.00
21.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULANCE SERVICES				23.00
24.00 CMHC		0	0	24.00
24.10 CORF	0	0	0	24.10
25.00 AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00 HOSPICE				26.00
27.00 PHYSICIAN FEES AND EDUCATION	1,888,736	0	1,888,736	27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	26,576,049	709,163	27,285,212	28.00
<b>PART II - OPERATING EXPENSES</b>				
29.00 Operating expenses (per wkst. A, column 3, line 200)		14,734,154		29.00
30.00 ADD (SPECIFY)	0			30.00
31.00	0			31.00
32.00	0			32.00
33.00	0			33.00
34.00	0			34.00
35.00	0			35.00
36.00 Total additions (sum of lines 30-35)		0		36.00
37.00 DEDUCT (SPECIFY)	0			37.00
38.00	0			38.00
39.00	0			39.00
40.00	0			40.00
41.00	0			41.00
42.00 Total deductions (sum of lines 37-41)		0		42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		14,734,154		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 144013

Period:  
From 05/01/2010  
To 04/30/2011

Worksheet G-3

Date/Time Prepared:  
11/8/2011 12:52 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	27,285,212	1.00
2.00	Less contractual allowances and discounts on patients' accounts	11,741,811	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,543,401	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	14,734,154	4.00
5.00	Net income from service to patients (line 3 minus line 4)	809,247	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	22,220	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	6,129	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	62,546	24.00
25.00	Total other income (sum of lines 6-24)	90,895	25.00
26.00	Total (line 5 plus line 25)	900,142	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	900,142	29.00