

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet S Parts I-III Date/Time Prepared: 1/24/2013 7:53 am
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 1/24/2013	Time: 7:53 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Kindred Hospital Chicago Central ( 142009 ) for the cost reporting period beginning 09/01/2011 and ending 08/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V 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	6,074	-93,036	0	1,584,667	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	6,074	-93,036	0	1,584,667	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: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part I Date/Time Prepared: 1/22/2013 9:39 am
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	1.00	2.00	3.00	4.00								
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 4058 West Melrose Street		PO Box:						1.00			
2.00	City: Chicago		State: IL		Zip Code: 60641		County: Cook		2.00			
	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)						
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00				
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		Kindred Hospital Chicago Central		142009	16974	2	07/01/1994	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
						From:		To:				
						1.00		2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					09/01/2011		08/31/2012		20.00		
21.00	Type of Control (see instructions)							4		21.00		
Inpatient PPS Information												
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N		N		22.00		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2		N		23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days					
		1.00	2.00	3.00	4.00	5.00	6.00					
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.					0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.					0	0	0	0	0	0	25.00
						Urban/Rural S		Date of Geogr				
						1.00		2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.							1		26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.							1		27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0		35.00		
						Beginning:		Ending:				
						1.00		2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.									36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 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: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part I Date/Time Prepared: 1/22/2013 9:39 am			
		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 additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
<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 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 in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00		0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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	If line 63 is yes, then, for each primary care residency program in which you are training residents, 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 that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000
				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.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	71.00
<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 and "N" for no.				Y	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.					86.00

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		V	XIX				
		1.00	2.00				
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y				90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N				91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N				92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N				93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N				94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00				95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N				96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00				97.00
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N					105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)						107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N					108.00
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
				1.00	2.00	3.00	
<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. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1				118.00
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	178,041	55,095	1,218,726			
			1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N				118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N		N		120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N				121.00
<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

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		1.00	2.00				
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	189003		140.00		
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: KINDRED HEALTHCARE INC	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		Contractor's Number: 05901			
142.00	Street: 680 SOUTH FOURTH AVENUE	PO Box:					
143.00	City: LOUISVILLE	State: KY		Zip Code: 40202			
			1.00				
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00		
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		Y		145.00		
			1.00	2.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00		
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
				1.00			
<b>Multi campus</b>							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N	165.00		
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
166.01							0.00
166.02							0.00
166.03							0.00
							1.00
<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)						0
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part II Date/Time Prepared: 1/22/2013 9:39 am
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/31/2013
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N	
			1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		Description	Y/N	Date
		0	1.00	2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/31/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part II Date/Time Prepared: 1/22/2013 9:39 am
		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.	N		21.00
				1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>				
<b>Capital Related Cost</b>				
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			27.00
<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.			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
<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.			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
<b>Provider-Based Physicians</b>				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
<b>Home Office Costs</b>				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2012	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00
				1.00
				2.00
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN	HOURIGAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	KINDRED HEALTHCARE INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5025967856	Daniel.Hourigan@kindred.com	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/31/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/22/2013 9:39 am

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	187	68,442	0.00		1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		187	68,442	0.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		187	68,442	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	44.00	0	0			19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		187				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: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/22/2013 9:39 am

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	18,797	11,756	34,404		1.00
2.00 HMO		442	664			2.00
3.00 HMO IPF Subprovider		0	0			3.00
4.00 HMO IRF Subprovider		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	18,797	11,756	34,404		7.00
8.00 INTENSIVE CARE UNIT	0	0	0	0		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0	18,797	11,756	34,404		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	0	0	0	0		19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	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		881				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/22/2013 9:39 am

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	702	1.00
2.00 HMO					19	2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	270.40	0.00	0	702	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00	0.00	0.00			19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	270.40	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: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/22/2013 9:39 am

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)	397	1,213		1.00
2.00 HMO				2.00
3.00 HMO IPF Subprovider				3.00
4.00 HMO IRF Subprovider				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	397	1,213		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet S-3  
Part II  
Date/Time Prepared:  
1/22/2013 9:39 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>PART II - WAGE DATA</b>						
<b>SALARIES</b>						
1.00	Total salaries (see instructions)	200.00	16,818,003	-25,550	16,792,453	562,675.00 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00 4.01
5.00	Physician-Part B		0	0	0	0.00 5.00
6.00	Non-physician-Part B		0	0	0	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00 7.01
8.00	Home office personnel		0	0	0	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00 9.00
10.00	Excluded area salaries (see instructions)		0	96,419	96,419	2,607.00 10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>						
11.00	Contract Labor (see instructions)		2,944,358	0	2,944,358	51,501.00 11.00
12.00	Contract management and administrative services		0	0	0	0.00 12.00
13.00	Contract Labor: Physician-Part A - Administrative		1,410,832	0	1,410,832	17,716.00 13.00
14.00	Home office salaries & wage-related costs		1,973,555	0	1,973,555	41,339.00 14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00 15.00
16.00	Home office and Contract Physicians Part A - Administrative		0	0	0	0.00 16.00
<b>WAGE-RELATED COSTS</b>						
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		2,683,127	0	2,683,127	17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		0	0	0	18.00
19.00	Excluded areas		15,471	0	15,471	19.00
20.00	Non-physician anesthetist Part A		0	0	0	20.00
21.00	Non-physician anesthetist Part B		0	0	0	21.00
22.00	Physician Part A - Administrative		0	0	0	22.00
22.01	Physician Part A - Teaching		0	0	0	22.01
23.00	Physician Part B		0	0	0	23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0	24.00
25.00	Interns & residents (in an approved program)		0	0	0	25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>						
26.00	Employee Benefits	4.00	43,335	0	43,335	1,072.00 26.00
27.00	Administrative & General	5.00	2,041,237	0	2,041,237	54,039.00 27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00 28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00 29.00
30.00	Operation of Plant	7.00	220,795	-25,550	195,245	15,282.00 30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00 31.00
32.00	Housekeeping	9.00	0	0	0	0.00 32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00 33.00
34.00	Dietary	10.00	0	0	0	0.00 34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00 35.00
36.00	Cafeteria	11.00	0	0	0	0.00 36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00 37.00
38.00	Nursing Administration	13.00	1,593,942	0	1,593,942	37,306.00 38.00
39.00	Central Services and Supply	14.00	145,673	0	145,673	8,722.00 39.00
40.00	Pharmacy	15.00	0	0	0	0.00 40.00
41.00	Medical Records & Medical Records Library	16.00	621,721	0	621,721	20,614.00 41.00
42.00	Social Service	17.00	523,471	-96,419	427,052	11,549.00 42.00
43.00	Other General Service	18.00	0	0	0	0.00 43.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet S-3 Part II Date/Time Prepared: 1/22/2013 9:39 am
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		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
<b>PART II - WAGE DATA</b>			
<b>SALARIES</b>			
1.00	Total salaries (see instructions)	29.84	1.00
2.00	Non-physician anesthetist Part A	0.00	2.00
3.00	Non-physician anesthetist Part B	0.00	3.00
4.00	Physician-Part A - Administrative	0.00	4.00
4.01	Physicians - Part A - Teaching	0.00	4.01
5.00	Physician-Part B	0.00	5.00
6.00	Non-physician-Part B	0.00	6.00
7.00	Interns & residents (in an approved program)	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)	0.00	7.01
8.00	Home office personnel	0.00	8.00
9.00	SNF	0.00	9.00
10.00	Excluded area salaries (see instructions)	36.98	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>			
11.00	Contract labor (see instructions)	57.17	11.00
12.00	Contract management and administrative services	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative	79.64	13.00
14.00	Home office salaries & wage-related costs	47.74	14.00
15.00	Home office: Physician Part A - Administrative	0.00	15.00
16.00	Home office and Contract Physicians Part A - Administrative	0.00	16.00
<b>WAGE-RELATED COSTS</b>			
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		18.00
19.00	Excluded areas		19.00
20.00	Non-physician anesthetist Part A		20.00
21.00	Non-physician anesthetist Part B		21.00
22.00	Physician Part A - Administrative		22.00
22.01	Physician Part A - Teaching		22.01
23.00	Physician Part B		23.00
24.00	Wage-related costs (RHC/FQHC)		24.00
25.00	Interns & residents (in an approved program)		25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>			
26.00	Employee Benefits	40.42	26.00
27.00	Administrative & General	37.77	27.00
28.00	Administrative & General under contract (see inst.)	0.00	28.00
29.00	Maintenance & Repairs	0.00	29.00
30.00	Operation of Plant	12.78	30.00
31.00	Laundry & Linen Service	0.00	31.00
32.00	Housekeeping	0.00	32.00
33.00	Housekeeping under contract (see instructions)	0.00	33.00
34.00	Dietary	0.00	34.00
35.00	Dietary under contract (see instructions)	0.00	35.00
36.00	Cafeteria	0.00	36.00
37.00	Maintenance of Personnel	0.00	37.00
38.00	Nursing Administration	42.73	38.00
39.00	Central Services and Supply	16.70	39.00
40.00	Pharmacy	0.00	40.00
41.00	Medical Records & Medical Records Library	30.16	41.00
42.00	Social Service	36.98	42.00
43.00	Other General Service	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet S-3  
Part III  
Date/Time Prepared:  
1/22/2013 9:39 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>						
1.00	Net salaries (see instructions)	16,818,003	-25,550	16,792,453	562,675.00	1.00
2.00	Excluded area salaries (see instructions)	0	96,419	96,419	2,607.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	16,818,003	-121,969	16,696,034	560,068.00	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,328,745	0	6,328,745	110,556.00	4.00
5.00	Subtotal wage-related costs (see inst.)	2,683,127	0	2,683,127	0.00	5.00
6.00	Total (sum of lines 3 thru 5)	25,829,875	-121,969	25,707,906	670,624.00	6.00
7.00	Total overhead cost (see instructions)	5,190,174	-121,969	5,068,205	148,584.00	7.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet S-3  
Part III  
Date/Time Prepared:  
1/22/2013 9:39 am

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>			
1.00	Net salaries (see instructions)	29.84	1.00
2.00	Excluded area salaries (see instructions)	36.98	2.00
3.00	Subtotal salaries (line 1 minus line 2)	29.81	3.00
4.00	Subtotal other wages & related costs (see inst.)	57.24	4.00
5.00	Subtotal wage-related costs (see inst.)	16.07	5.00
6.00	Total (sum of lines 3 thru 5)	38.33	6.00
7.00	Total overhead cost (see instructions)	34.11	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet S-3 Part IV Date/Time Prepared: 1/22/2013 9:39 am
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			55,013 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)			713,341 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			118 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			12,256 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			73,384 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			334,562 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			1,191,571 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			253,976 20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			48,906 23.00
24.00	<b>Total Wage Related cost (Sum of lines 1 -23)</b>			<b>2,683,127 24.00</b>
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 142009		Period: From 09/01/2011 To 08/31/2012		Worksheet A	
Date/Time Prepared: 1/22/2013 9:39 am							
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS-BLDG & FIXT		3,902,922	3,902,922	345,096	4,248,018	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		1,255,076	1,255,076	376,906	1,631,982	2.00
3.00 00300	OTHER CAP REL COSTS		722,002	722,002	-722,002	0	3.00
4.00 00400	EMPLOYEE BENEFITS	43,335	2,798,351	2,841,686	0	2,841,686	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,041,237	8,800,224	10,841,461	0	10,841,461	5.00
7.00 00700	OPERATION OF PLANT	220,795	2,932,822	3,153,617	0	3,153,617	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	334,895	334,895	0	334,895	8.00
9.00 00900	HOUSEKEEPING	0	977,925	977,925	0	977,925	9.00
10.00 01000	DIETARY	0	1,090,178	1,090,178	0	1,090,178	10.00
11.00 01100	CAFETERIA	0	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,593,942	34,099	1,628,041	0	1,628,041	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	145,673	54,300	199,973	0	199,973	14.00
15.00 01500	PHARMACY	0	1,131,972	1,131,972	0	1,131,972	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	621,721	177,942	799,663	0	799,663	16.00
17.00 01700	SOCIAL SERVICE	523,471	44,023	567,494	-104,407	463,087	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	6,833,952	1,844,871	8,678,823	1,940,701	10,619,524	30.00
31.00 03100	INTENSIVE CARE UNIT	1,919,326	21,375	1,940,701	-1,940,701	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	178,903	357,683	536,586	0	536,586	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	172,391	492,155	664,546	0	664,546	54.00
60.00 06000	LABORATORY	202,334	1,184,195	1,386,529	0	1,386,529	60.00
65.00 06500	RESPIRATORY THERAPY	2,320,923	139,767	2,460,690	0	2,460,690	65.00
66.00 06600	PHYSICAL THERAPY	0	1,687,256	1,687,256	0	1,687,256	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,820,396	1,820,396	0	1,820,396	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	2,269,640	2,269,640	0	2,269,640	73.00
74.00 07400	RENAL DIALYSIS	0	801,284	801,284	0	801,284	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	16,818,003	34,875,353	51,693,356	-104,407	51,588,949	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CASE MANAGER	0	0	0	104,407	104,407	194.00
194.01 07951	IDLE SPACE	0	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06 07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07 07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00	TOTAL (SUM OF LINES 118-199)	16,818,003	34,875,353	51,693,356	0	51,693,356	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A  
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Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	301	4,248,319	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	61,375	1,693,357	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	-8,432	2,833,254	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,143,851	8,697,610	5.00
7.00	00700	OPERATION OF PLANT	-37,996	3,115,621	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	334,895	8.00
9.00	00900	HOUSEKEEPING	0	977,925	9.00
10.00	01000	DIETARY	0	1,090,178	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,628,041	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	199,973	14.00
15.00	01500	PHARMACY	0	1,131,972	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,562	797,101	16.00
17.00	01700	SOCIAL SERVICE	0	463,087	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-141,701	10,477,823	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-104,593	431,993	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	664,546	54.00
60.00	06000	LABORATORY	0	1,386,529	60.00
65.00	06500	RESPIRATORY THERAPY	3,493	2,464,183	65.00
66.00	06600	PHYSICAL THERAPY	-91,520	1,595,736	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,820,396	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,269,640	73.00
74.00	07400	RENAL DIALYSIS	0	801,284	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,465,486	49,123,463	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	104,407	194.00
194.01	07951	IDLE SPACE	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	194.11
200.00		TOTAL (SUM OF LINES 118-199)	-2,465,486	49,227,870	200.00

RECLASSIFICATIONS

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-6  
Date/Time Prepared:  
1/22/2013 9:39 am

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
A - RECLASS NON ALLOWABLE CASE MANAGER						
1.00	NONALLOWABLE CASE MANAGER		194.00	96,419	7,988	1.00
	TOTALS			96,419	7,988	
C - RECLASS ICU EXPENSE						
1.00	ADULTS & PEDIATRICS		30.00	1,919,326	21,375	1.00
	TOTALS			1,919,326	21,375	
E - RECLASS PT TRANSPORTATION						
1.00	OPERATION OF PLANT		7.00	0	25,550	1.00
	TOTALS			0	25,550	
500.00	Grand Total: Increases			2,015,745	54,913	500.00

RECLASSIFICATIONS

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-6  
Date/Time Prepared:  
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		Decreases							
		Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
		6.00	7.00	8.00	9.00	10.00			
A - RECLASS NON ALLOWABLE CASE MANAGER									
1.00		SOCIAL SERVICE	17.00	96,419	7,988	0		1.00	
		TOTALS		96,419	7,988				
C - RECLASS ICU EXPENSE									
1.00		INTENSIVE CARE UNIT	31.00	1,919,326	21,375	0		1.00	
		TOTALS		1,919,326	21,375				
E - RECLASS PT TRANSPORTATION									
1.00		OPERATION OF PLANT	7.00	25,550	0	0		1.00	
		TOTALS		25,550	0				
500.00		Grand Total: Decreases		2,041,295	29,363			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
1/22/2013 9:39 am

	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	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	69,408	0	0	0	3.00
4.00	Building Improvements	7,639,160	600,538	0	600,538	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	8,327,624	747,387	0	747,387	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,036,192	1,347,925	0	1,347,925	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,036,192	1,347,925	0	1,347,925	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	566,212	3,336,710	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	471,572	783,504	0	0	2.00
3.00	Total (sum of lines 1-2)	1,037,784	4,120,214	0	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	8,309,106	0	8,309,106	0.477971	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,075,011	0	9,075,011	0.522029	2.00
3.00	Total (sum of lines 1-2)	17,384,117	0	17,384,117	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
1/22/2013 9:39 am

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	69,408	0			3.00
4.00	Building Improvements	8,239,698	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	9,075,011	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	17,384,117	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	17,384,117	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	3,902,922			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,255,076			2.00
3.00	Total (sum of lines 1-2)	0	5,157,998			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	316,497	0	345,096	576,749	3,336,710
2.00	CAP REL COSTS-MVBLE EQUIP	345,670	0	376,906	532,947	783,504
3.00	Total (sum of lines 1-2)	662,167	0	722,002	1,109,696	4,120,214

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	18,363	316,497	0	4,248,319	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	31,236	345,670	0	1,693,357	2.00
3.00	Total (sum of lines 1-2)	0	49,599	662,167	0	5,941,676	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-8

Date/Time Prepared:  
1/22/2013 9:39 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line #	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT		1.00	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP		2.00	2.00
3.00 Investment income - other (chapter 2)		0			0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-1,175	ADMINISTRATIVE & GENERAL		5.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-39,138	ADMINISTRATIVE & GENERAL		5.00	7.00
8.00 Television and radio service (chapter 21)	A	-2,282	OPERATION OF PLANT		7.00	8.00
9.00 Parking lot (chapter 21)		0			0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-242,801				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	216,136				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Cafeteria-employees and guests		0			0.00	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	-2,562	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		ORESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			OCAP REL COSTS-BLDG & FIXT		1.00	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			OCAP REL COSTS-MVBLE EQUIP		2.00	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***		19.00	28.00
29.00 Physicians' assistant			0		0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY		67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	32.00
33.00			0		0.00	33.00
33.01 MISCELLANEOUS INCOME	B	-30,808	ADMINISTRATIVE & GENERAL		5.00	33.01
33.02			0		0.00	33.02
33.03			0		0.00	33.03
33.04			0		0.00	33.04
33.05 OCCUPATIONAL INCENTIVE INCOME	A	-39,219	ADMINISTRATIVE & GENERAL		5.00	33.05
33.06			0		0.00	33.06
33.07 PROFESSIONAL FEES - CAPITAL PROJECT	A	-7,571	ADMINISTRATIVE & GENERAL		5.00	33.07
33.08 MEDICARE BAD DEBT - PART A	A	-1,913,021	ADMINISTRATIVE & GENERAL		5.00	33.08
33.09			0		0.00	33.09
33.10 OTHER MEDICARE NON ALLOWABLE	A	-57,731	ADMINISTRATIVE & GENERAL		5.00	33.10
33.11 OTHER OPERATING - PATIENT RELATIONS	A	-3,314	ADMINISTRATIVE & GENERAL		5.00	33.11
33.12			0		0.00	33.12
33.13 OTHER OPERATING - MARKETING	A	-203,424	ADMINISTRATIVE & GENERAL		5.00	33.13
33.14			0		0.00	33.14
33.15			0		0.00	33.15
33.16			0		0.00	33.16
33.17			0		0.00	33.17
33.18			0		0.00	33.18
33.19			0		0.00	33.19
33.20 OTHER OPERATING - TRADE SHOW BOOTH	A	-634	ADMINISTRATIVE & GENERAL		5.00	33.20
33.21			0		0.00	33.21

ADJUSTMENTS TO EXPENSES

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-8

Date/Time Prepared:  
1/22/2013 9:39 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center	Line #	
			1.00	2.00	3.00
33.22		0		0.00	33.22
33.23	A	-9,828	ADMINISTRATIVE & GENERAL	5.00	33.23
33.24		0		0.00	33.24
33.25	A	-18	ADMINISTRATIVE & GENERAL	5.00	33.25
33.26		0		0.00	33.26
33.27	A	-325,681	ADMINISTRATIVE & GENERAL	5.00	33.27
33.28	A	65,936	ADMINISTRATIVE & GENERAL	5.00	33.28
33.29	A	-38,944	ADMINISTRATIVE & GENERAL	5.00	33.29
33.30		0		0.00	33.30
33.31	A	1,238	ADMINISTRATIVE & GENERAL	5.00	33.31
33.32	A	7,011	ADMINISTRATIVE & GENERAL	5.00	33.32
33.33		0		0.00	33.33
33.34	A	132,766	ADMINISTRATIVE & GENERAL	5.00	33.34
33.35	A	55,095	ADMINISTRATIVE & GENERAL	5.00	33.35
33.36		0		0.00	33.36
33.37	A	-2,764	ADMINISTRATIVE & GENERAL	5.00	33.37
33.38	A	-10,532	CAP REL COSTS-BLDG & FIXT	1.00	33.38
33.39	A	-54,896	CAP REL COSTS-MVBLE EQUIP	2.00	33.39
33.40	A	21,069	CAP REL COSTS-BLDG & FIXT	1.00	33.40
33.41	A	116,271	CAP REL COSTS-MVBLE EQUIP	2.00	33.41
33.42		0		0.00	33.42
33.43		0		0.00	33.43
33.44	A	-13,265	ADMINISTRATIVE & GENERAL	5.00	33.44
33.45		0		0.00	33.45
33.46	A	-10,236	CAP REL COSTS-BLDG & FIXT	1.00	33.46
33.47		0		0.00	33.47
33.48		0		0.00	33.48
33.49		0		0.00	33.49
33.50		0		0.00	33.50
33.51		0		0.00	33.51
33.52		0		0.00	33.52
33.53		0		0.00	33.53
33.54		0		0.00	33.54
33.55		0		0.00	33.55
33.56		0		0.00	33.56
33.57		0		0.00	33.57
33.58		0		0.00	33.58
33.59		0		0.00	33.59
33.60	A	-27,018	ADMINISTRATIVE & GENERAL	5.00	33.60
33.61	A	-4,180	EMPLOYEE BENEFITS	4.00	33.61
33.62		0		0.00	33.62
33.63		0		0.00	33.63
33.64		0		0.00	33.64
33.65		0		0.00	33.65
33.66		0		0.00	33.66
33.67		0		0.00	33.67
33.68		0		0.00	33.68
33.69		0		0.00	33.69
33.70		0		0.00	33.70
33.71		0		0.00	33.71
33.72		0		0.00	33.72
33.73		0		0.00	33.73
33.74	A	-7,251	ADULTS & PEDIATRICS	30.00	33.74
33.75		0		0.00	33.75
33.76		0		0.00	33.76
33.77	A	73	OPERATING ROOM	50.00	33.77
33.78		0		0.00	33.78
33.79		0		0.00	33.79
33.80	A	7,178	RESPIRATORY THERAPY	65.00	33.80
33.81		0		0.00	33.81
33.82		0		0.00	33.82
33.83		0		0.00	33.83
33.84		0		0.00	33.84
33.85		0		0.00	33.85
33.86		0		0.00	33.86
33.87		0		0.00	33.87
33.88		0		0.00	33.88
33.89	A	-10,164	OPERATION OF PLANT	7.00	33.89
33.90	A	-4,252	EMPLOYEE BENEFITS	4.00	33.90

ADJUSTMENTS TO EXPENSES

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-8

Date/Time Prepared:  
1/22/2013 9:39 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center	Line #	
			1.00	2.00	
33.91 VAN SERVICE SALARY	A	-25,550	OPERATION OF PLANT	7.00	33.91
33.92		0		0.00	33.92
33.93		0		0.00	33.93
33.94		0		0.00	33.94
33.95		0		0.00	33.95
33.96		0		0.00	33.96
33.97		0		0.00	33.97
33.98		0		0.00	33.98
33.99		0		0.00	33.99
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,465,486			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-8  
Date/Time Prepared:  
1/22/2013 9:39 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (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 - CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00		0	33.00
33.01	MISCELLANEOUS INCOME	0	33.01
33.02		0	33.02
33.03		0	33.03
33.04		0	33.04
33.05	OCCUPATIONAL INCENTIVE INCOME	0	33.05
33.06		0	33.06
33.07	PROFESSIONAL FEES - CAPITAL PROJECT	0	33.07
33.08	MEDICARE BAD DEBT - PART A	0	33.08
33.09		0	33.09
33.10	OTHER MEDICARE NON ALLOWABLE	0	33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	0	33.11
33.12		0	33.12
33.13	OTHER OPERATING - MARKETING	0	33.13
33.14		0	33.14
33.15		0	33.15
33.16		0	33.16
33.17		0	33.17
33.18		0	33.18
33.19		0	33.19
33.20	OTHER OPERATING - TRADE SHOW BOOTH	0	33.20
33.21		0	33.21
33.22		0	33.22
33.23	CHARITABLE CONTRIBUTIONS	0	33.23
33.24		0	33.24
33.25	OTHER OPERATING - PENALTIES OTHER	0	33.25
33.26		0	33.26
33.27	MALPRACTICE FINITE COST	0	33.27

ADJUSTMENTS TO EXPENSES

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-8

Date/Time Prepared:  
1/22/2013 9:39 am

Cost Center Description	Wkst. A-7 Ref.	
	5.00	
33.28 AGGREGATE CAPITAL EROSION	0	33.28
33.29 CABLE TV AND SATELLITE	0	33.29
33.30	0	33.30
33.31 MARKETING BONUS	0	33.31
33.32 RENT - VENTAS OTHER	0	33.32
33.33	0	33.33
33.34 MALPRACTICE TAIL LIABILITY	0	33.34
33.35 AGGREGATE CAP PYMT-NONALLOWABLE	0	33.35
33.36	0	33.36
33.37 PHYSICIAN BILLING COLLECTION FEES	0	33.37
33.38 MEDICARE VS BOOK BLDG	9	33.38
33.39 MEDICARE VS BOOK MOV EQUIP	9	33.39
33.40 ASSET ADD-ON BLDG	9	33.40
33.41 ASSET ADD-ON MOV EQUIP	9	33.41
33.42	0	33.42
33.43	0	33.43
33.44 NON ALLOWABLE LOBBYING FEES	0	33.44
33.45	0	33.45
33.46 BUSINESS INTERRUPTION INS PREMIUM	12	33.46
33.47	0	33.47
33.48	0	33.48
33.49	0	33.49
33.50	0	33.50
33.51	0	33.51
33.52	0	33.52
33.53	0	33.53
33.54	0	33.54
33.55	0	33.55
33.56	0	33.56
33.57	0	33.57
33.58	0	33.58
33.59	0	33.59
33.60 DISTRICT OFFICE SALES AND MARKETING	0	33.60
33.61 DISTRICT OFC SALES AND MKT BENEFITS	0	33.61
33.62	0	33.62
33.63	0	33.63
33.64	0	33.64
33.65	0	33.65
33.66	0	33.66
33.67	0	33.67
33.68	0	33.68
33.69	0	33.69
33.70	0	33.70
33.71	0	33.71
33.72	0	33.72
33.73	0	33.73
33.74 PHYSICIAN FEE ADJUSTMENT	0	33.74
33.75	0	33.75
33.76	0	33.76
33.77 PHYSICIAN FEE ADJUSTMENT	0	33.77
33.78	0	33.78
33.79	0	33.79
33.80 PHYSICIAN FEE ADJUSTMENT	0	33.80
33.81	0	33.81
33.82	0	33.82
33.83	0	33.83
33.84	0	33.84
33.85	0	33.85
33.86	0	33.86
33.87	0	33.87
33.88	0	33.88
33.89 VAN SERVICE VEHICLE MAINTENANCE	0	33.89
33.90 VAN SERVICE EE BENEFITS	0	33.90
33.91 VAN SERVICE SALARY	0	33.91
33.92	0	33.92
33.93	0	33.93
33.94	0	33.94
33.95	0	33.95
33.96	0	33.96
33.97	0	33.97
33.98	0	33.98
33.99	0	33.99
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: 142009

Period: From 09/01/2011 To 08/31/2012

Worksheet A-8-1

Date/Time Prepared: 1/22/2013 9:39 am

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00		5.00 ADMINISTRATIVE & GENERAL	Home Office Costs	1.00
2.00		4.00 EMPLOYEE BENEFITS	Workers Comp Premium	2.00
3.00		5.00 ADMINISTRATIVE & GENERAL	Liability Insurance	3.00
4.00		0.00		4.00
4.01		66.00 PHYSICAL THERAPY	Therapy Services	4.01
4.02		50.00 OPERATING ROOM	Hospital Related services	4.02
4.03		54.00 RADIOLOGY-DIAGNOSTIC	Hospital Related services	4.03
4.04		60.00 LABORATORY	Hospital Related services	4.04
4.05		0.00		4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

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

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

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

6.00	B	Kindred Inc-Hos	100.00	6.00
7.00	B	Kindred Inc-Hos	100.00	7.00
8.00	B	Kindred Inc-Hos	100.00	8.00
9.00			0.00	9.00
10.00	B	Kindred Inc-Hos	100.00	10.00
10.01	B	Kindred Inc-Hos	100.00	10.01
10.02	B	Kindred Inc-Hos	100.00	10.02
10.03	B	Kindred Inc-Hos	100.00	10.03
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: 142009

Period: From 09/01/2011 To 08/31/2012

Worksheet A-8-1

Date/Time Prepared: 1/22/2013 9:39 am

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>						
1.00	3,033,393	2,725,737	307,656	0		1.00
2.00	297,492	297,492	0	0		2.00
3.00	1,309,926	1,309,926	0	0		3.00
4.00	0	0	0	0		4.00
4.01	1,594,431	1,685,951	-91,520	0		4.01
4.02	151,429	151,429	0	0		4.02
4.03	223,103	223,103	0	0		4.03
4.04	809,512	809,512	0	0		4.04
4.05	0	0	0	0		4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	7,419,286	7,203,150	216,136		5.00

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

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	

**B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:**

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

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

6.00	Admin & Gen	100.00	HomeOffice Cost	6.00
7.00	Cornerstone	100.00	Worker Comp Ins	7.00
8.00	Cornerstone	100.00	Liability Insur	8.00
9.00		0.00		9.00
10.00	RehabCare	100.00	Therapy Svcs	10.00
10.01	KH-North 4637	100.00	OR Svcs	10.01
10.02	KH-North 4637	100.00	Radiology Svcs	10.02
10.03	KH-North 4637	100.00	Lab	10.03
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: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-8-2

Date/Time Prepared:  
1/22/2013 9:39 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	30.00	DR. A	13,995	0	1.00
2.00	30.00	DR. B	11,644	0	2.00
3.00	30.00	DR. C	5,040	5,040	3.00
4.00	30.00	DR. D	4,560	4,560	4.00
5.00	50.00	DR. E	28,184	28,184	5.00
6.00	0.00	DR. F	0	0	6.00
7.00	30.00	DR. G	646,942	0	7.00
8.00	30.00	DR. H	3,510	0	8.00
9.00	50.00	DR. I	24,149	24,149	9.00
10.00	30.00	DR. J	357	0	10.00
11.00	30.00	DR. K	46,505	0	11.00
12.00	30.00	DR. L	27,623	27,623	12.00
13.00	30.00	DR. M	888	888	13.00
14.00	30.00	DR. N	8,002	0	14.00
15.00	30.00	DR. O	10,727	0	15.00
16.00	30.00	DR. P	3,055	0	16.00
17.00	30.00	DR. Q	11,644	0	17.00
18.00	65.00	DR. R	7,178	0	18.00
19.00	30.00	DR. S	5,040	5,040	19.00
20.00	30.00	DR. T	4,560	4,560	20.00
21.00	50.00	DR. U	28,184	28,184	21.00
22.00	0.00	DR. V	0	0	22.00
23.00	30.00	DR. W	639,328	0	23.00
24.00	30.00	DR. X	357	0	24.00
25.00	50.00	DR. Y	24,149	24,149	25.00
26.00	30.00	DR. Z	36,105	36,105	26.00
27.00	30.00	DR. A	1,070	1,070	27.00
28.00	0.00	DR. B	0	0	28.00
29.00	0.00	DR. C	0	0	29.00
30.00	0.00	DR. D	0	0	30.00
31.00	0.00	DR. E	0	0	31.00
32.00	0.00	DR. F	0	0	32.00
33.00	0.00	DR. G	0	0	33.00
34.00	0.00	DR. H	0	0	34.00
35.00	0.00	DR. I	0	0	35.00
36.00	0.00	DR. J	0	0	36.00
37.00	0.00	DR. K	0	0	37.00
38.00	0.00	DR. L	0	0	38.00
39.00	0.00	DR. M	0	0	39.00
40.00	0.00	DR. N	0	0	40.00
41.00	0.00	DR. O	0	0	41.00
42.00	0.00	DR. P	0	0	42.00
43.00	0.00	DR. Q	0	0	43.00
44.00	0.00	DR. R	0	0	44.00
45.00	0.00	DR. S	0	0	45.00
46.00	0.00	DR. T	0	0	46.00
47.00	0.00	DR. U	0	0	47.00
48.00	0.00	DR. V	0	0	48.00
49.00	0.00	DR. W	0	0	49.00
50.00	0.00	DR. X	0	0	50.00
200.00			1,592,796	189,552	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-8-2

Date/Time Prepared:  
1/22/2013 9:39 am

	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	13,995	177,200	82	6,986	349	1.00
2.00	11,644	177,200	75	6,389	319	2.00
3.00	0	177,200	0	0	0	3.00
4.00	0	177,200	0	0	0	4.00
5.00	0	200,300	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	646,942	177,200	8,512	725,157	36,258	7.00
8.00	3,510	177,200	39	3,323	166	8.00
9.00	0	200,300	0	0	0	9.00
10.00	357	177,200	3	256	13	10.00
11.00	46,505	177,200	276	23,513	1,176	11.00
12.00	0	177,200	0	0	0	12.00
13.00	0	177,200	0	0	0	13.00
14.00	8,002	177,200	47	4,004	200	14.00
15.00	10,727	177,200	83	7,071	354	15.00
16.00	3,055	177,200	24	2,045	102	16.00
17.00	11,644	177,200	75	6,389	319	17.00
18.00	7,178	177,200	41	3,493	175	18.00
19.00	0	177,200	0	0	0	19.00
20.00	0	177,200	0	0	0	20.00
21.00	0	200,300	0	0	0	21.00
22.00	0	0	0	0	0	22.00
23.00	639,328	177,200	8,412	716,638	35,832	23.00
24.00	357	177,200	3	256	13	24.00
25.00	0	200,300	0	0	0	25.00
26.00	0	177,200	0	0	0	26.00
27.00	0	177,200	0	0	0	27.00
28.00	0	0	0	0	0	28.00
29.00	0	0	0	0	0	29.00
30.00	0	0	0	0	0	30.00
31.00	0	0	0	0	0	31.00
32.00	0	0	0	0	0	32.00
33.00	0	0	0	0	0	33.00
34.00	0	0	0	0	0	34.00
35.00	0	0	0	0	0	35.00
36.00	0	0	0	0	0	36.00
37.00	0	0	0	0	0	37.00
38.00	0	0	0	0	0	38.00
39.00	0	0	0	0	0	39.00
40.00	0	0	0	0	0	40.00
41.00	0	0	0	0	0	41.00
42.00	0	0	0	0	0	42.00
43.00	0	0	0	0	0	43.00
44.00	0	0	0	0	0	44.00
45.00	0	0	0	0	0	45.00
46.00	0	0	0	0	0	46.00
47.00	0	0	0	0	0	47.00
48.00	0	0	0	0	0	48.00
49.00	0	0	0	0	0	49.00
50.00	0	0	0	0	0	50.00
200.00	1,403,244		17,672	1,505,520	75,276	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-8-2

Date/Time Prepared:  
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	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	6,986	1.00
2.00	0	0	0	0	6,389	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	725,157	7.00
8.00	0	0	0	0	3,323	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	256	10.00
11.00	0	0	0	0	23,513	11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	0	0	0	13.00
14.00	0	0	0	0	4,004	14.00
15.00	0	0	0	0	7,071	15.00
16.00	0	0	0	0	2,045	16.00
17.00	0	0	0	0	6,389	17.00
18.00	0	0	0	0	3,493	18.00
19.00	0	0	0	0	0	19.00
20.00	0	0	0	0	0	20.00
21.00	0	0	0	0	0	21.00
22.00	0	0	0	0	0	22.00
23.00	0	0	0	0	716,638	23.00
24.00	0	0	0	0	256	24.00
25.00	0	0	0	0	0	25.00
26.00	0	0	0	0	0	26.00
27.00	0	0	0	0	0	27.00
28.00	0	0	0	0	0	28.00
29.00	0	0	0	0	0	29.00
30.00	0	0	0	0	0	30.00
31.00	0	0	0	0	0	31.00
32.00	0	0	0	0	0	32.00
33.00	0	0	0	0	0	33.00
34.00	0	0	0	0	0	34.00
35.00	0	0	0	0	0	35.00
36.00	0	0	0	0	0	36.00
37.00	0	0	0	0	0	37.00
38.00	0	0	0	0	0	38.00
39.00	0	0	0	0	0	39.00
40.00	0	0	0	0	0	40.00
41.00	0	0	0	0	0	41.00
42.00	0	0	0	0	0	42.00
43.00	0	0	0	0	0	43.00
44.00	0	0	0	0	0	44.00
45.00	0	0	0	0	0	45.00
46.00	0	0	0	0	0	46.00
47.00	0	0	0	0	0	47.00
48.00	0	0	0	0	0	48.00
49.00	0	0	0	0	0	49.00
50.00	0	0	0	0	0	50.00
200.00	0	0	0	0	1,505,520	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-8-2

Date/Time Prepared:  
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	RCE	Adjustment	
	Disallowance	18.00	
1.00	7,009	7,009	1.00
2.00	5,255	5,255	2.00
3.00	0	5,040	3.00
4.00	0	4,560	4.00
5.00	0	28,184	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	187	187	8.00
9.00	0	24,149	9.00
10.00	101	101	10.00
11.00	22,992	22,992	11.00
12.00	0	27,623	12.00
13.00	0	888	13.00
14.00	3,998	3,998	14.00
15.00	3,656	3,656	15.00
16.00	1,010	1,010	16.00
17.00	5,255	5,255	17.00
18.00	3,685	3,685	18.00
19.00	0	5,040	19.00
20.00	0	4,560	20.00
21.00	0	28,184	21.00
22.00	0	0	22.00
23.00	0	0	23.00
24.00	101	101	24.00
25.00	0	24,149	25.00
26.00	0	36,105	26.00
27.00	0	1,070	27.00
28.00	0	0	28.00
29.00	0	0	29.00
30.00	0	0	30.00
31.00	0	0	31.00
32.00	0	0	32.00
33.00	0	0	33.00
34.00	0	0	34.00
35.00	0	0	35.00
36.00	0	0	36.00
37.00	0	0	37.00
38.00	0	0	38.00
39.00	0	0	39.00
40.00	0	0	40.00
41.00	0	0	41.00
42.00	0	0	42.00
43.00	0	0	43.00
44.00	0	0	44.00
45.00	0	0	45.00
46.00	0	0	46.00
47.00	0	0	47.00
48.00	0	0	48.00
49.00	0	0	49.00
50.00	0	0	50.00
200.00	53,249	242,801	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142009

Period: From 09/01/2011 To 08/31/2012

Worksheet B Part I Date/Time Prepared: 1/22/2013 9:39 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,248,319	4,248,319			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,693,357		1,693,357		2.00
4.00 00400	EMPLOYEE BENEFITS	2,833,254	0	0	2,833,254	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,697,610	438,009	190,957	345,292	5.00
7.00 00700	OPERATION OF PLANT	3,115,621	653,918	285,086	33,027	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	334,895	24,553	10,704	0	8.00
9.00 00900	HOUSEKEEPING	977,925	94,035	40,996	0	9.00
10.00 01000	DIETARY	1,090,178	220,233	96,014	0	10.00
11.00 01100	CAFETERIA	0	56,480	24,623	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,628,041	67,586	29,465	269,628	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	199,973	151,699	66,136	24,642	14.00
15.00 01500	PHARMACY	1,131,972	80,174	34,953	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	797,101	42,530	18,542	105,169	16.00
17.00 01700	SOCIAL SERVICE	463,087	38,650	16,850	72,239	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	10,477,823	1,467,295	639,692	1,480,694	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	431,993	243,483	106,150	30,263	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	664,546	94,834	41,345	29,161	54.00
60.00 06000	LABORATORY	1,386,529	14,601	6,366	34,226	60.00
65.00 06500	RESPIRATORY THERAPY	2,464,183	89,029	38,814	392,603	65.00
66.00 06600	PHYSICAL THERAPY	1,595,736	96,789	42,197	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,820,396	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,269,640	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	801,284	5,983	2,608	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09900	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	49,123,463	3,879,881	1,691,498	2,816,944	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,265	1,859	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CASE MANAGER	104,407	0	0	16,310	194.00
194.01 07951	IDLE SPACE	0	364,173	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07 07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	49,227,870	4,248,319	1,693,357	2,833,254	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet B  
Part I  
Date/Time Prepared:  
1/22/2013 9:39 am

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	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	9,671,868					5.00
7.00	00700	999,476	5,087,128				7.00
8.00	00800	90,506	44,732	505,390			8.00
9.00	00900	272,130	171,321	0	1,556,407		9.00
10.00	01000	343,886	401,242	0	128,205	2,279,758	10.00
11.00	01100	19,831	102,901	0	32,879	1,152,676	11.00
13.00	01300	487,731	123,135	0	39,344	0	13.00
14.00	01400	108,184	276,380	0	88,309	0	14.00
15.00	01500	304,929	146,068	0	46,672	0	15.00
16.00	01600	235,548	77,486	0	24,758	0	16.00
17.00	01700	144,463	70,417	0	22,500	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	3,439,161	2,673,255	505,390	854,158	1,085,622	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	198,516	443,600	0	141,739	0	50.00
54.00	05400	202,916	172,778	0	55,206	0	54.00
60.00	06000	352,517	26,602	0	8,500	0	60.00
65.00	06500	729,775	162,202	0	51,827	0	65.00
66.00	06600	424,159	176,339	0	56,344	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	445,107	0	0	0	0	71.00
73.00	07300	554,952	0	0	0	0	73.00
74.00	07400	198,023	10,900	0	3,483	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	05950	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		9,551,810	5,079,358	505,390	1,553,924	2,238,298	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	1,497	7,770	0	2,483	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	29,517	0	0	0	0	194.00
194.01	07951	89,044	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	41,460	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		9,671,868	5,087,128	505,390	1,556,407	2,279,758	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet B  
Part I  
Date/Time Prepared:  
1/22/2013 9:39 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,389,390					11.00
13.00	01300	105,970	2,750,900				13.00
14.00	01400	23,549	0	938,872			14.00
15.00	01500	0	0	5,259	1,750,027		15.00
16.00	01600	58,872	0	854	0	1,360,860	16.00
17.00	01700	41,211	0	19	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	877,201	2,714,464	14,717	54,207	548,057	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	11,774	36,436	0	0	8,682	50.00
54.00	05400	11,774	0	475	426	47,207	54.00
60.00	06000	41,211	0	1,132	0	107,145	60.00
65.00	06500	217,828	0	2,417	0	239,591	65.00
66.00	06600	0	0	754	0	46,149	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	913,240	0	70,630	71.00
73.00	07300	0	0	0	1,695,394	270,760	73.00
74.00	07400	0	0	5	0	22,639	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	05950	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		1,389,390	2,750,900	938,872	1,750,027	1,360,860	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,389,390	2,750,900	938,872	1,750,027	1,360,860	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet B  
Part I  
Date/Time Prepared:  
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE	869,436			17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	869,436	27,701,172	0	27,701,172	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	1,652,636	0	1,652,636	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,320,668	0	1,320,668	54.00
60.00	06000	LABORATORY	0	1,978,829	0	1,978,829	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,388,269	0	4,388,269	65.00
66.00	06600	PHYSICAL THERAPY	0	2,438,467	0	2,438,467	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,249,373	0	3,249,373	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,790,746	0	4,790,746	73.00
74.00	07400	RENAL DIALYSIS	0	1,044,925	0	1,044,925	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	869,436	48,565,085	0	48,565,085	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,874	0	17,874	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	150,234	0	150,234	194.00
194.01	07951	IDLE SPACE	0	453,217	0	453,217	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	41,460	0	41,460	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	869,436	49,227,870	0	49,227,870	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet B  
Part II  
Date/Time Prepared:  
1/22/2013 9:39 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS
		BLDG & FIXT	MVBLE EQUIP		
		0	1.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	309,701	438,009	190,957	5.00
7.00 00700	OPERATION OF PLANT	0	653,918	285,086	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	24,553	10,704	8.00
9.00 00900	HOUSEKEEPING	0	94,035	40,996	9.00
10.00 01000	DIETARY	0	220,233	96,014	10.00
11.00 01100	CAFETERIA	0	56,480	24,623	11.00
13.00 01300	NURSING ADMINISTRATION	0	67,586	29,465	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	151,699	66,136	14.00
15.00 01500	PHARMACY	0	80,174	34,953	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	42,530	18,542	16.00
17.00 01700	SOCIAL SERVICE	0	38,650	16,850	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000	ADULTS & PEDIATRICS	0	1,467,295	639,692	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000	OPERATING ROOM	0	243,483	106,150	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	94,834	41,345	54.00
60.00 06000	LABORATORY	0	14,601	6,366	60.00
65.00 06500	RESPIRATORY THERAPY	0	89,029	38,814	65.00
66.00 06600	PHYSICAL THERAPY	0	96,789	42,197	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	5,983	2,608	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000	CLINIC	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 09500	AMBULANCE SERVICES	0	0	0	95.00
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00	SUBTOTALS (SUM OF LINES 1-117)	309,701	3,879,881	1,691,498	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,265	1,859	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00 07950	NONALLOWABLE CASE MANAGER	0	0	0	194.00
194.01 07951	IDLE SPACE	0	364,173	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	194.05
194.06 07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	194.06
194.07 07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	194.11
200.00	Cross Foot Adjustments			0	200.00
201.00	Negative Cost Centers			0	201.00
202.00	TOTAL (sum lines 118-201)	309,701	4,248,319	1,693,357	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet B Part II Date/Time Prepared: 1/22/2013 9:39 am				
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	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	938,667				5.00	
7.00	00700	OPERATION OF PLANT	97,000	1,036,004			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	8,784	9,110	53,151		8.00	
9.00	00900	HOUSEKEEPING	26,410	34,890	0	196,331	9.00	
10.00	01000	DIETARY	33,374	81,714	0	16,172	10.00	
11.00	01100	CAFETERIA	1,925	20,956	0	4,147	11.00	
13.00	01300	NURSING ADMINISTRATION	47,335	25,077	0	4,963	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	10,499	56,285	0	11,140	14.00	
15.00	01500	PHARMACY	29,594	29,747	0	5,887	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	22,860	15,780	0	3,123	16.00	
17.00	01700	SOCIAL SERVICE	14,020	14,341	0	2,838	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	333,778	544,412	53,151	107,748	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	19,266	90,340	0	17,880	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,693	35,187	0	6,964	54.00	
60.00	06000	LABORATORY	34,212	5,418	0	1,072	60.00	
65.00	06500	RESPIRATORY THERAPY	70,825	33,033	0	6,538	65.00	
66.00	06600	PHYSICAL THERAPY	41,165	35,912	0	7,107	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,198	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	53,859	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	19,218	2,220	0	439	74.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	91.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00	
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00	
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	927,015	1,034,422	53,151	196,018	439,369	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	145	1,582	0	313	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	2,865	0	0	0	0	194.00
194.01	07951	IDLE SPACE	8,642	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	8,138	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	938,667	1,036,004	53,151	196,331	447,507	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet B Part II Date/Time Prepared: 1/22/2013 9:39 am
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	334,397					11.00
13.00	01300	25,505	199,931				13.00
14.00	01400	5,668	0	301,427			14.00
15.00	01500	0	0	1,688	182,043		15.00
16.00	01600	14,169	0	274	0	117,278	16.00
17.00	01700	9,919	0	6	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	211,122	197,283	4,725	5,639	47,203	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	2,834	2,648	0	0	749	50.00
54.00	05400	2,834	0	152	44	4,070	54.00
60.00	06000	9,919	0	363	0	9,237	60.00
65.00	06500	52,427	0	776	0	20,656	65.00
66.00	06600	0	0	242	0	3,979	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	293,200	0	6,089	71.00
73.00	07300	0	0	0	176,360	23,343	73.00
74.00	07400	0	0	1	0	1,952	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	05950	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		334,397	199,931	301,427	182,043	117,278	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		334,397	199,931	301,427	182,043	117,278	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet B Part II Date/Time Prepared: 1/22/2013 9:39 am			
Cost Center	Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE	96,624			17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	96,624	3,921,775	0	3,921,775	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	483,350	0	483,350	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	205,123	0	205,123	54.00
60.00	06000	LABORATORY	0	81,188	0	81,188	60.00
65.00	06500	RESPIRATORY THERAPY	0	312,098	0	312,098	65.00
66.00	06600	PHYSICAL THERAPY	0	227,391	0	227,391	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	342,487	0	342,487	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	253,562	0	253,562	73.00
74.00	07400	RENAL DIALYSIS	0	32,421	0	32,421	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	96,624	5,859,395	0	5,859,395	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,164	0	8,164	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	2,865	0	2,865	194.00
194.01	07951	IDLE SPACE	0	372,815	0	372,815	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	8,138	0	8,138	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	96,624	6,251,377	0	6,251,377	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet B-1  
Date/Time Prepared:  
1/22/2013 9:39 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	143,441				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		131,145			2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	16,749,118		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	14,789	14,789	2,041,237	-9,671,868	5.00
7.00 00700	OPERATION OF PLANT	22,079	22,079	195,245	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	829	829	0	0	8.00
9.00 00900	HOUSEKEEPING	3,175	3,175	0	0	9.00
10.00 01000	DIETARY	7,436	7,436	0	0	10.00
11.00 01100	CAFETERIA	1,907	1,907	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	2,282	2,282	1,593,942	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	5,122	5,122	145,673	0	14.00
15.00 01500	PHARMACY	2,707	2,707	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,436	1,436	621,721	0	16.00
17.00 01700	SOCIAL SERVICE	1,305	1,305	427,052	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	49,542	49,542	8,753,278	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	8,221	8,221	178,903	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,202	3,202	172,391	0	54.00
60.00 06000	LABORATORY	493	493	202,334	0	60.00
65.00 06500	RESPIRATORY THERAPY	3,006	3,006	2,320,923	0	65.00
66.00 06600	PHYSICAL THERAPY	3,268	3,268	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	202	202	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09800	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	131,001	131,001	16,652,699	-9,671,868	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	144	144	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CASE MANAGER	0	0	96,419	0	194.00
194.01 07951	IDLE SPACE	12,296	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07 07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4,248,319	1,693,357	2,833,254	9,671,868	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	29.617188	12.912097	0.169158	0.244511	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	938,667	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.023730	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	94,277				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	829	34,404			8.00
9.00	00900	HOUSEKEEPING	3,175	0	90,273		9.00
10.00	01000	DIETARY	7,436	0	7,436	100,737	10.00
11.00	01100	CAFETERIA	1,907	0	1,907	50,934	236
13.00	01300	NURSING ADMINISTRATION	2,282	0	2,282	0	18
14.00	01400	CENTRAL SERVICES & SUPPLY	5,122	0	5,122	0	4
15.00	01500	PHARMACY	2,707	0	2,707	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,436	0	1,436	0	10
17.00	01700	SOCIAL SERVICE	1,305	0	1,305	0	7
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	49,542	34,404	49,542	47,971	149
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	8,221	0	8,221	0	2
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,202	0	3,202	0	2
60.00	06000	LABORATORY	493	0	493	0	7
65.00	06500	RESPIRATORY THERAPY	3,006	0	3,006	0	37
66.00	06600	PHYSICAL THERAPY	3,268	0	3,268	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	202	0	202	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09500	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	94,133	34,404	90,129	98,905	236
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	144	0	144	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0	0
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09	07958	VISITOR MEALS	0	0	0	1,832	0
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
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)	5,087,128	505,390	1,556,407	2,279,758	1,389,390
203.00		Unit cost multiplier (Wkst. B, Part I)	53.959375	14.689862	17.241113	22.630791	5,887.245763
204.00		Cost to be allocated (per Wkst. B, Part II)	1,036,004	53,151	196,331	447,507	334,397
205.00		Unit cost multiplier (Wkst. B, Part II)	10.988937	1.544908	2.174858	4.442330	1,416.936441

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet B-1  
Date/Time Prepared:  
1/22/2013 9:39 am

Cost Center Description		NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	151					13.00
14.00	01400	0	1,871,484				14.00
15.00	01500	0	10,482	2,342,777			15.00
16.00	01600	0	1,703	0	176,159,119		16.00
17.00	01700	0	37	0	0	34,404	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	149	29,335	72,567	70,941,742	34,404	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	2	0	0	1,123,886	0	50.00
54.00	05400	0	946	570	6,110,928	0	54.00
60.00	06000	0	2,256	0	13,869,877	0	60.00
65.00	06500	0	4,818	0	31,015,078	0	65.00
66.00	06600	0	1,502	0	5,974,000	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	1,820,396	0	9,143,092	0	71.00
73.00	07300	0	0	2,269,640	35,049,877	0	73.00
74.00	07400	0	9	0	2,930,639	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	09800	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		151	1,871,484	2,342,777	176,159,119	34,404	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00							201.00
202.00		2,750,900	938,872	1,750,027	1,360,860	869,436	202.00
203.00		18,217.880795	0.501672	0.746988	0.007725	25.271364	203.00
204.00		199,931	301,427	182,043	117,278	96,624	204.00
205.00		1,324.046358	0.161063	0.077704	0.000666	2.808511	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet C Part I Date/Time Prepared: 1/22/2013 9:39 am
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		27,701,172	49,564	27,750,736	30.00
31.00	03100 INTENSIVE CARE UNIT		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY		0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		1,652,636	0	1,652,636	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,320,668	0	1,320,668	54.00
60.00	06000 LABORATORY		1,978,829	0	1,978,829	60.00
65.00	06500 RESPIRATORY THERAPY	0	4,388,269	3,685	4,391,954	65.00
66.00	06600 PHYSICAL THERAPY	0	2,438,467	0	2,438,467	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		3,249,373	0	3,249,373	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		4,790,746	0	4,790,746	73.00
74.00	07400 RENAL DIALYSIS		1,044,925	0	1,044,925	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		0	0	0	90.00
91.00	09100 EMERGENCY		0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS		0	0	0	98.00
200.00	Subtotal (see instructions)		48,565,085	53,249	48,618,334	200.00
201.00	Less Observation Beds		0	0	0	201.00
202.00	Total (see instructions)		48,565,085	53,249	48,618,334	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 142009		Period: From 09/01/2011 To 08/31/2012		Worksheet C Part I Date/Time Prepared: 1/22/2013 9:39 am	
			Title XVIII		Hospital		PPS	
Cost Center Description	Charges			Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient						
	6.00	7.00	8.00					
	9.00	10.00						
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	70,941,742		70,941,742			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,123,886	0	1,123,886	1.470466	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,110,928	0	6,110,928	0.216116	0.000000	54.00
60.00	06000	LABORATORY	13,869,877	0	13,869,877	0.142671	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	31,015,078	0	31,015,078	0.141488	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,974,000	0	5,974,000	0.408180	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,143,092	0	9,143,092	0.355391	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,049,877	0	35,049,877	0.136684	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,930,639	0	2,930,639	0.356552	0.000000	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	176,159,119	0	176,159,119			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	176,159,119	0	176,159,119			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet C Part I Date/Time Prepared: 1/22/2013 9:39 am
		Title XVIII	Hospital	PPS
Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	1.470466		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.216116		54.00
60.00	06000 LABORATORY	0.142671		60.00
65.00	06500 RESPIRATORY THERAPY	0.141607		65.00
66.00	06600 PHYSICAL THERAPY	0.408180		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.355391		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.136684		73.00
74.00	07400 RENAL DIALYSIS	0.356552		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet C Part I Date/Time Prepared: 1/22/2013 9:39 am
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE		
				Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		27,701,172	49,564	27,750,736	30.00
31.00	03100 INTENSIVE CARE UNIT		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY		0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		1,652,636	0	1,652,636	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,320,668	0	1,320,668	54.00
60.00	06000 LABORATORY		1,978,829	0	1,978,829	60.00
65.00	06500 RESPIRATORY THERAPY	0	4,388,269	3,685	4,391,954	65.00
66.00	06600 PHYSICAL THERAPY	0	2,438,467	0	2,438,467	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		3,249,373	0	3,249,373	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		4,790,746	0	4,790,746	73.00
74.00	07400 RENAL DIALYSIS		1,044,925	0	1,044,925	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		0	0	0	90.00
91.00	09100 EMERGENCY		0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS		0	0	0	98.00
200.00	Subtotal (see instructions)		48,565,085	53,249	48,618,334	200.00
201.00	Less Observation Beds		0	0	0	201.00
202.00	Total (see instructions)		48,565,085	53,249	48,618,334	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 142009		Period: From 09/01/2011 To 08/31/2012		Worksheet C Part I Date/Time Prepared: 1/22/2013 9:39 am	
			Title XVIII		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00					
9.00	10.00							
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	70,941,742		70,941,742			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,123,886	0	1,123,886	1.470466	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,110,928	0	6,110,928	0.216116	0.000000	54.00
60.00	06000	LABORATORY	13,869,877	0	13,869,877	0.142671	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	31,015,078	0	31,015,078	0.141488	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,974,000	0	5,974,000	0.408180	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,143,092	0	9,143,092	0.355391	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,049,877	0	35,049,877	0.136684	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,930,639	0	2,930,639	0.356552	0.000000	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	176,159,119	0	176,159,119			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	176,159,119	0	176,159,119			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet C Part I Date/Time Prepared: 1/22/2013 9:39 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	1.470466		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.216116		54.00
60.00	06000 LABORATORY	0.142671		60.00
65.00	06500 RESPIRATORY THERAPY	0.141607		65.00
66.00	06600 PHYSICAL THERAPY	0.408180		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.355391		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.136684		73.00
74.00	07400 RENAL DIALYSIS	0.356552		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet C Part I Date/Time Prepared: 1/22/2013 9:39 am
		Title XIX	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs					
			Total Costs	RCE Disallowance	Total Costs			
							1.00	2.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000 ADULTS & PEDIATRICS		27,701,172		27,701,172	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT		0		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY		0		0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000 OPERATING ROOM		1,652,636		1,652,636	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,320,668		1,320,668	0	0	54.00
60.00	06000 LABORATORY		1,978,829		1,978,829	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	4,388,269	0	4,388,269	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	2,438,467	0	2,438,467	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		3,249,373		3,249,373	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		4,790,746		4,790,746	0	0	73.00
74.00	07400 RENAL DIALYSIS		1,044,925		1,044,925	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000 CLINIC		0		0	0	0	90.00
91.00	09100 EMERGENCY		0		0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500 AMBULANCE SERVICES		0		0	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS		0		0	0	0	98.00
200.00	Subtotal (see instructions)		48,565,085	0	48,565,085	0	0	200.00
201.00	Less Observation Beds		0		0	0	0	201.00
202.00	Total (see instructions)		48,565,085	0	48,565,085	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 142009		Period: From 09/01/2011 To 08/31/2012		Worksheet C Part I Date/Time Prepared: 1/22/2013 9:39 am	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00					
9.00	10.00							
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	70,941,742		70,941,742			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,123,886	0	1,123,886	1.470466	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,110,928	0	6,110,928	0.216116	0.000000	54.00
60.00	06000	LABORATORY	13,869,877	0	13,869,877	0.142671	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	31,015,078	0	31,015,078	0.141488	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,974,000	0	5,974,000	0.408180	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,143,092	0	9,143,092	0.355391	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,049,877	0	35,049,877	0.136684	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,930,639	0	2,930,639	0.356552	0.000000	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	176,159,119	0	176,159,119			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	176,159,119	0	176,159,119			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet C Part I Date/Time Prepared: 1/22/2013 9:39 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 142009		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part I Date/Time Prepared: 1/22/2013 9:39 am	
Cost Center Description		Title XVIII		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,921,775	0	3,921,775	34,404	113.99 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0.00 31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0.00 44.00
200.00		Total (lines 30-199)	3,921,775		3,921,775	34,404	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part I Date/Time Prepared: 1/22/2013 9:39 am
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
			6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	18,797	2,142,670	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
200.00		Total (lines 30-199)	18,797	2,142,670	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part II Date/Time Prepared: 1/22/2013 9:39 am
		Title XVIII		Hospital
				PPS

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	483,350	1,123,886	0.430070	601,560	258,713	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	205,123	6,110,928	0.033567	3,252,713	109,184	54.00
60.00	06000	LABORATORY	81,188	13,869,877	0.005854	7,896,306	46,225	60.00
65.00	06500	RESPIRATORY THERAPY	312,098	31,015,078	0.010063	15,383,574	154,805	65.00
66.00	06600	PHYSICAL THERAPY	227,391	5,974,000	0.038063	3,452,512	131,413	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	342,487	9,143,092	0.037459	5,025,527	188,251	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	253,562	35,049,877	0.007234	18,841,330	136,298	73.00
74.00	07400	RENAL DIALYSIS	32,421	2,930,639	0.011063	1,506,699	16,669	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (Lines 50-199)	1,937,620	105,217,377		55,960,221	1,041,558	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142009		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part III Date/Time Prepared: 1/22/2013 9:39 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142009		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part III Date/Time Prepared: 1/22/2013 9:39 am	
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)	PPS	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,404	0.00	18,797	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	34,404		18,797	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part IV Date/Time Prepared: 1/22/2013 9:39 am
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet D  
Part IV  
Date/Time Prepared:  
1/22/2013 9:39 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	1,123,886	0.000000	0.000000	601,560	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	6,110,928	0.000000	0.000000	3,252,713	54.00
60.00	06000 LABORATORY	0	13,869,877	0.000000	0.000000	7,896,306	60.00
65.00	06500 RESPIRATORY THERAPY	0	31,015,078	0.000000	0.000000	15,383,574	65.00
66.00	06600 PHYSICAL THERAPY	0	5,974,000	0.000000	0.000000	3,452,512	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,143,092	0.000000	0.000000	5,025,527	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	35,049,877	0.000000	0.000000	18,841,330	73.00
74.00	07400 RENAL DIALYSIS	0	2,930,639	0.000000	0.000000	1,506,699	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0.000000	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00	Total (Lines 50-199)	0	105,217,377			55,960,221	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part IV Date/Time Prepared: 1/22/2013 9:39 am
	Title XVIII	Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	0	0	0		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00	Total (Lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet D  
Part V  
Date/Time Prepared:  
1/22/2013 9:39 am

		Title XVIII		Hospital		PPS	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges				
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00	4.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1.470466	0	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.216116	0	751,896	0		54.00
60.00	06000 LABORATORY	0.142671	0	24,290	0		60.00
65.00	06500 RESPIRATORY THERAPY	0.141488	0	472,955	0		65.00
66.00	06600 PHYSICAL THERAPY	0.408180	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.355391	0	48	0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.136684	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0.356552	0	689,262	0		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0		90.00
91.00	09100 EMERGENCY	0.000000	0	0	0		91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0.000000		0			95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0		98.00
200.00	Subtotal (see instructions)		0	1,938,451	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	1,938,451	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part V Date/Time Prepared: 1/22/2013 9:39 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs					
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
5.00	6.00	7.00				
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	162,497	0	54.00
60.00	06000	LABORATORY	0	3,465	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	66,917	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	245,758	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES		0		95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
200.00		Subtotal (see instructions)	0	478,654	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	478,654	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 142009		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part I Date/Time Prepared: 1/22/2013 9:39 am	
Cost Center Description		Title XVIII		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,921,775	0	3,921,775	34,404	113.99 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0.00 31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0.00 44.00
200.00		Total (lines 30-199)	3,921,775		3,921,775	34,404	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part I Date/Time Prepared: 1/22/2013 9:39 am
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
			6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	18,797	2,142,670	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
200.00		Total (lines 30-199)	18,797	2,142,670	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 142009		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part II Date/Time Prepared: 1/22/2013 9:39 am	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	483,350	1,123,886	0.430070	601,560	258,713	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	205,123	6,110,928	0.033567	3,252,713	109,184	54.00
60.00	06000	LABORATORY	81,188	13,869,877	0.005854	7,896,306	46,225	60.00
65.00	06500	RESPIRATORY THERAPY	312,098	31,015,078	0.010063	15,383,574	154,805	65.00
66.00	06600	PHYSICAL THERAPY	227,391	5,974,000	0.038063	3,452,512	131,413	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	342,487	9,143,092	0.037459	5,025,527	188,251	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	253,562	35,049,877	0.007234	18,841,330	136,298	73.00
74.00	07400	RENAL DIALYSIS	32,421	2,930,639	0.011063	1,506,699	16,669	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (Lines 50-199)	1,937,620	105,217,377		55,960,221	1,041,558	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142009		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part III Date/Time Prepared: 1/22/2013 9:39 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142009		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part III Date/Time Prepared: 1/22/2013 9:39 am	
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)	PPS	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,404	0.00	18,797	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	34,404		18,797	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part IV Date/Time Prepared: 1/22/2013 9:39 am
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part IV Date/Time Prepared: 1/22/2013 9:39 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	1,123,886	0.000000	0.000000	601,560	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	6,110,928	0.000000	0.000000	3,252,713	54.00
60.00	06000 LABORATORY	0	13,869,877	0.000000	0.000000	7,896,306	60.00
65.00	06500 RESPIRATORY THERAPY	0	31,015,078	0.000000	0.000000	15,383,574	65.00
66.00	06600 PHYSICAL THERAPY	0	5,974,000	0.000000	0.000000	3,452,512	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,143,092	0.000000	0.000000	5,025,527	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	35,049,877	0.000000	0.000000	18,841,330	73.00
74.00	07400 RENAL DIALYSIS	0	2,930,639	0.000000	0.000000	1,506,699	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0.000000	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00	Total (Lines 50-199)	0	105,217,377			55,960,221	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part IV Date/Time Prepared: 1/22/2013 9:39 am
	Title XVIII	Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	0	0	0		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00	Total (Lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet D  
Part V  
Date/Time Prepared:  
1/22/2013 9:39 am

		Title XVIII		Hospital		PPS		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			1.00	2.00				3.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1.470466	0	0	0	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216116	0	751,896	0	54.00	
60.00	06000	LABORATORY	0.142671	0	24,290	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.141488	0	472,955	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.408180	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.355391	0	48	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.136684	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.356552	0	689,262	0	74.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	90.00	
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	95.00	
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	98.00	
200.00		Subtotal (see instructions)		0	1,938,451	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00	
202.00		Net Charges (line 200 +/- line 201)		0	1,938,451	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part V Date/Time Prepared: 1/22/2013 9:39 am
Title XVIII		Hospital	PPS

Cost Center Description	Costs					
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
5.00	6.00	7.00				
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	162,497	0	54.00
60.00	06000	LABORATORY	0	3,465	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	66,917	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	245,758	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES		0		95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
200.00		Subtotal (see instructions)	0	478,654	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	478,654	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1 Date/Time Prepared: 1/22/2013 9:39 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		34,404	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		34,404	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		34,404	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)		18,797	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)		27,750,736	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)		27,750,736	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		70,941,742	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		70,941,742	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.391176	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)		2,062.02	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)		27,750,736	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)		806.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		15,161,848	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		15,161,848	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1 Date/Time Prepared: 1/22/2013 9:39 am
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					11,200,331 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					26,362,179 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,142,670 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,041,558 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					3,184,228 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					23,177,951 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142009		Period: From 09/01/2011 To 08/31/2012		Worksheet D-1 Date/Time Prepared: 1/22/2013 9:39 am	
Title XVIII		Hospital		PPS			
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,921,775	27,750,736	0.141321	0	0	90.00
91.00	Nursing School cost	0	27,750,736	0.000000	0	0	91.00
92.00	Allied health cost	0	27,750,736	0.000000	0	0	92.00
93.00	All other Medical Education	0	27,750,736	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1 Date/Time Prepared: 1/22/2013 9:39 am
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)		34,404	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		34,404	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		34,404	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)		11,756	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)		27,701,172	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)		27,701,172	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		70,941,742	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		70,941,742	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.390478	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)		2,062.02	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)		27,701,172	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)		805.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,465,579	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)		9,465,579	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1 Date/Time Prepared: 1/22/2013 9:39 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00
42.00	Intensive Care Type Inpatient Hospital Units					42.00
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,376,690
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					15,842,269
<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
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
<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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
<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
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet D-1  
Date/Time Prepared:  
1/22/2013 9:39 am

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet D-3 Date/Time Prepared: 1/22/2013 9:39 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		38,682,282		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.470466	601,560	884,574	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.216116	3,252,713	702,963	54.00
60.00	06000 LABORATORY	0.142671	7,896,306	1,126,574	60.00
65.00	06500 RESPIRATORY THERAPY	0.141607	15,383,574	2,178,422	65.00
66.00	06600 PHYSICAL THERAPY	0.408180	3,452,512	1,409,246	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.355391	5,025,527	1,786,027	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.136684	18,841,330	2,575,308	73.00
74.00	07400 RENAL DIALYSIS	0.356552	1,506,699	537,217	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		55,960,221	11,200,331	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		55,960,221		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet D-3 Date/Time Prepared: 1/22/2013 9:39 am	
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	03000 ADULTS & PEDIATRICS		24,150,024		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	1.470466	411,209	604,669	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.216116	1,191,259	257,450	54.00
60.00	06000 LABORATORY	0.142671	3,026,906	431,852	60.00
65.00	06500 RESPIRATORY THERAPY	0.141488	10,903,210	1,542,673	65.00
66.00	06600 PHYSICAL THERAPY	0.408180	1,360,535	555,343	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.355391	3,087,244	1,097,179	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.136684	12,327,116	1,684,920	73.00
74.00	07400 RENAL DIALYSIS	0.356552	568,232	202,604	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		32,875,711	6,376,690	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)		32,875,711		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet E Part B Date/Time Prepared: 1/22/2013 9:39 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		478,654	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		478,654	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		1,938,451	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		1,938,451	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,938,451	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,459,797	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		478,654	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		387,690	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		90,964	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		90,964	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		90,964	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		90,964	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		90,964	40.00
41.00	Interim payments		184,000	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		-93,036	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 142009		Period: From 09/01/2011 To 08/31/2012		Worksheet E-1 Part I Date/Time Prepared: 1/22/2013 9:39 am	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		30,559,019		184,000	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	12/01/2011	249,200		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	11/28/2012	55,100		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		194,100		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		30,753,119		184,000	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		6,074		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		93,036	6.02	
7.00	Total Medicare program liability (see instructions)		30,759,193		90,964	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet E-3 Part IV Date/Time Prepared: 1/22/2013 9:39 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART IV - MEDICARE PART A SERVICES - LTCH PPS</b>				
1.00	Net Federal PPS Payments (see instructions)		31,763,692	1.00
2.00	Outlier Payments		589,881	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		32,353,573	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition		0	5.00
6.00	Cost of teaching physicians		0	6.00
7.00	Subtotal (see instructions)		32,353,573	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8)		32,353,573	9.00
10.00	Deductibles		28,660	10.00
11.00	Subtotal (line 9 minus line 10)		32,324,913	11.00
12.00	Coinsurance		2,904,241	12.00
13.00	Subtotal (line 11 minus line 12)		29,420,672	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		1,912,173	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		1,338,521	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,761,985	16.00
17.00	Subtotal (sum of lines 13 and 15)		30,759,193	17.00
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.99	Recovery of Accelerated Depreciation		0	21.99
22.00	Total amount payable to the provider (see instructions)		30,759,193	22.00
23.00	Interim payments		30,753,119	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus the sum lines 23 and 24)		6,074	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	26.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part IV, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet E-3 Part IV Date/Time Prepared: 1/22/2013 9:39 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART IV - MEDICARE PART A SERVICES - LTCH PPS</b>				
1.00	Net Federal PPS Payments (see instructions)		31,763,692	1.00
2.00	Outlier Payments		589,881	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		32,353,573	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition		0	5.00
6.00	Cost of teaching physicians		0	6.00
7.00	Subtotal (see instructions)		32,353,573	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8)		32,353,573	9.00
10.00	Deductibles		28,660	10.00
11.00	Subtotal (line 9 minus line 10)		32,324,913	11.00
12.00	Coinsurance		2,904,241	12.00
13.00	Subtotal (line 11 minus line 12)		29,420,672	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		1,912,173	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		1,338,521	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,761,985	16.00
17.00	Subtotal (sum of lines 13 and 15)		30,759,193	17.00
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.99	Recovery of Accelerated Depreciation		0	21.99
22.00	Total amount payable to the provider (see instructions)		30,759,193	22.00
23.00	Interim payments		30,753,119	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus the sum lines 23 and 24)		6,074	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	26.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part IV, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 1/22/2013 9:39 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<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		15,842,269		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)		15,842,269	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		15,842,269	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		24,150,024		8.00
9.00	Ancillary service charges		32,875,711	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		57,025,735	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		57,025,735	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		41,183,466	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		15,842,269	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		15,842,269	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		15,842,269	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		15,842,269	0	36.00
37.00	OTHER ADJUSTMENTS		0		37.00
37.01	OTHER ADJUSTMENTS		0		37.01
38.00	Subtotal (line 36 ± line 37)		15,842,269	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		15,842,269	0	40.00
41.00	Interim payments		14,257,602		41.00
42.00	Balance due provider/program (line 40 minus 41)		1,584,667		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0		43.00

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

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet G

Date/Time Prepared:  
1/22/2013 9:39 am

		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	-32,816	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	14,756,071	0	0	0	4.00
5.00	Other receivable	933	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,435,374	0	0	0	6.00
7.00	Inventory	378,097	0	0	0	7.00
8.00	Prepaid expenses	119,493	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)	13,786,404	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	231,365	0	0	0	15.00
16.00	Accumulated depreciation	-222,253	0	0	0	16.00
17.00	Leasehold improvements	8,077,741	0	0	0	17.00
18.00	Accumulated depreciation	-7,221,689	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	9,075,010	0	0	0	23.00
24.00	Accumulated depreciation	-7,632,134	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)	2,308,040	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	41,351	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	41,351	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	16,135,795	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,062,348	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,564,558	0	0	0	38.00
39.00	Payroll taxes payable	32,088	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	1,061,730	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,720,724	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-21,075,028	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-21,075,028	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-17,354,304	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	33,490,099				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	33,490,099	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	16,135,795	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet G-1

Date/Time Prepared:  
1/22/2013 9:39 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		30,142,736	
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,347,364			2.00
3.00	Total (sum of line 1 and line 2)		33,490,100		0	3.00
4.00	Additions (credit adjustments)	0		0		4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		33,490,100		0	11.00
12.00	Deductions (debit adjustments)	0		0		12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	1		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		1		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		33,490,099		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet G-1

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
1/22/2013 9:39 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	70,941,742		70,941,742	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	70,941,742		70,941,742	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	70,941,742		70,941,742	17.00
18.00	Ancillary services	105,217,377	0	105,217,377	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	176,159,119	0	176,159,119	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		51,693,356		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)		51,693,356		43.00

## STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 142009

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet G-3

Date/Time Prepared:  
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	176,159,119	1.00
2.00	Less contractual allowances and discounts on patients' accounts	121,171,151	2.00
3.00	Net patient revenues (line 1 minus line 2)	54,987,968	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	51,693,356	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,294,612	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	1,175	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	0	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	2,562	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	49,015	24.00
25.00	Total other income (sum of lines 6-24)	52,752	25.00
26.00	Total (line 5 plus line 25)	3,347,364	26.00
27.00	OTHER EXPENSES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,347,364	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 142009	Period: From 09/01/2011 To 08/31/2012	Worksheet I-5 Date/Time Prepared: 1/22/2013 9:39 am
				1.00
1.00	Total expenses related to care of program beneficiaries (see instructions)		0	1.00
2.00	Total payment (from Worksheet I-4, column 6, line 11)		0	2.00
3.00	Deductibles billed to Medicare (Part B) patients		0	3.00
4.00	Coinsurance billed to Medicare (Part B) patients		0	4.00
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries		0	5.00
6.00				6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (sum of lines 3 and 4 less line 5)		0	8.00
9.00	Program payment (line 2 less line 3, times 80 percent)		0	9.00
10.00	Unrecovered from Medicare (Part B) patients (Line 1 minus the sum of lines 8 and 9. If negative, enter zero and do not complete line 11.)		0	10.00
11.00	Reimbursable bad debts (lesser of line 10 or line 5) (transfer to Worksheet E, Part B, line 33)		0	11.00