

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: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet S Parts I-III Date/Time Prepared: 1/24/2013 9:32 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 1/24/2013 Time: 9:32 am	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 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 Springfield (142014) 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			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	97,236	0	0	874,523	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	97,236	0	0	874,523	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: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part I Date/Time Prepared: 1/24/2013 9:31 am
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1.00	Hospital and Hospital Health Care Complex Address:	2.00	3.00	4.00	1.00
1.00	Street: 701 North Walnut Street	PO Box:	Zip Code: 62702	County: Sangamon	1.00
2.00	City: Springfield	State: IL			2.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		

3.00	Hospital and Hospital-Based Component Identification:									
	Hospital	Kindred Hospital Springfield	142014	44100	2	09/01/2011	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	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	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	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: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part I Date/Time Prepared: 1/24/2013 9:31 am			
		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00	
46.00	Is this facility eligible for 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	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME Average	Direct GME Average			
		1.00	2.00	3.00			
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00		0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital received HRSA PCRE funding (see instructions)	0.00				62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part I Date/Time Prepared: 1/24/2013 9:31 am		
		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
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have 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
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have 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		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				Y	80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part I Date/Time Prepared: 1/24/2013 9:31 am		
		V	XIX			
		1.00	2.00			
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y			90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N			91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N			92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N			93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N			94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00			95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N			96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00			97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If 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 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	27,822	8,313	193,631		118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
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
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00

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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
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	189003			
		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 PHYSICIAN SERVICES		Contractor's Number: 52280		141.00
142.00	Street: 680 SOUTH FOURTH AVENUE	PO Box:				142.00
143.00	City: LOUISVILLE	State: KY		Zip Code: 40202		143.00
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			Y		145.00
				1.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00
		Part A	Part B	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	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
				1.00		
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5					0.00
166.01						0.00
166.02						0.00
166.03						0.00
				1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.			N		167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part II Date/Time Prepared: 1/24/2013 9:31 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	11/30/2012	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: 142014

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

Worksheet S-2
Part II
Date/Time Prepared:
1/24/2013 9:31 am

		Part A		
Description		Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			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.			35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2012	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
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN	HOURIGAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	KINDRED HEALTHCARE 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	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/30/2012	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		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT 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: 142014

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

Worksheet S-3
Part I
Date/Time Prepared:
1/24/2013 9:31 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number		Avai lable		
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	50	18,300	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)		50	18,300	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)		50	18,300	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)		50			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: 142014

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

Worksheet S-3
Part I
Date/Time Prepared:
1/24/2013 9:31 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	3,566	1,048	5,841		1.00
2.00 HMO		107	0			2.00
3.00 HMO IPF Subprovider		0	0			3.00
4.00 HMO IRF Subprovider		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	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	3,566	1,048	5,841		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	3,566	1,048	5,841		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		46				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142014

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

Worksheet S-3
Part I
Date/Time Prepared:
1/24/2013 9:31 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	141	1.00
2.00 HMO					5	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	66.70	0.00	0	141	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	66.70	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: 142014

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

Worksheet S-3
Part I
Date/Time Prepared:
1/24/2013 9:31 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)	30	220		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)	30	220		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: 142014

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

Worksheet S-3
Part II
Date/Time Prepared:
1/24/2013 9:31 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	
PART II - WAGE DATA						
SALARIES						
1.00	Total salaries (see instructions)	200.00	4,005,885	0	4,005,885	138,968.00 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	8,183	8,183	244.00 10.00
OTHER WAGES & RELATED COSTS						
11.00	Contract Labor (see instructions)		1,169,769	0	1,169,769	18,231.00 11.00
12.00	Contract management and administrative services		0	0	0	0.00 12.00
13.00	Contract Labor: Physician-Part A - Administrative		62,726	0	62,726	307.00 13.00
14.00	Home office salaries & wage-related costs		454,024	0	454,024	9,510.34 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
WAGE-RELATED COSTS						
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		700,597	0	700,597	17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		0	0	0	18.00
19.00	Excluded areas		1,434	0	1,434	19.00
20.00	Non-physician anesthetist Part A		0	0	0	20.00
21.00	Non-physician anesthetist Part B		0	0	0	21.00
22.00	Physician Part A - Administrative		0	0	0	22.00
22.01	Physician Part A - Teaching		0	0	0	22.01
23.00	Physician Part B		0	0	0	23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0	24.00
25.00	Interns & residents (in an approved program)		0	0	0	25.00
OVERHEAD COSTS - DIRECT SALARIES						
26.00	Employee Benefits	4.00	4,278	0	4,278	98.00 26.00
27.00	Administrative & General	5.00	756,840	0	756,840	15,840.00 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	107,140	0	107,140	7,988.00 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	578,272	0	578,272	14,484.00 38.00
39.00	Central Services and Supply	14.00	72,212	0	72,212	4,109.00 39.00
40.00	Pharmacy	15.00	0	0	0	0.00 40.00
41.00	Medical Records & Medical Records Library	16.00	185,861	0	185,861	7,169.00 41.00
42.00	Social Service	17.00	138,227	-8,183	130,044	3,879.00 42.00
43.00	Other General Service	18.00	0	0	0	0.00 43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142014

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

Worksheet S-3
Part II
Date/Time Prepared:
1/24/2013 9:31 am

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
PART II - WAGE DATA			
SALARIES			
1.00	Total salaries (see instructions)	28.83	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)	33.54	10.00
OTHER WAGES & RELATED COSTS			
11.00	Contract labor (see instructions)	64.16	11.00
12.00	Contract management and administrative services	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative	204.32	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
WAGE-RELATED COSTS			
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
OVERHEAD COSTS - DIRECT SALARIES			
26.00	Employee Benefits	43.65	26.00
27.00	Administrative & General	47.78	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	13.41	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	39.92	38.00
39.00	Central Services and Supply	17.57	39.00
40.00	Pharmacy	0.00	40.00
41.00	Medical Records & Medical Records Library	25.93	41.00
42.00	Social Service	33.53	42.00
43.00	Other General Service	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142014

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

Worksheet S-3
Part III
Date/Time Prepared:
1/24/2013 9:31 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	
PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)	4,005,885	0	4,005,885	138,968.00	1.00
2.00	Excluded area salaries (see instructions)	0	8,183	8,183	244.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	4,005,885	-8,183	3,997,702	138,724.00	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,686,519	0	1,686,519	28,048.34	4.00
5.00	Subtotal wage-related costs (see inst.)	700,597	0	700,597	0.00	5.00
6.00	Total (sum of lines 3 thru 5)	6,393,001	-8,183	6,384,818	166,772.34	6.00
7.00	Total overhead cost (see instructions)	1,842,830	-8,183	1,834,647	53,567.00	7.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142014

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

Worksheet S-3
Part III
Date/Time Prepared:
1/24/2013 9:31 am

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	28.83	1.00
2.00	Excluded area salaries (see instructions)	33.54	2.00
3.00	Subtotal salaries (line 1 minus line 2)	28.82	3.00
4.00	Subtotal other wages & related costs (see inst.)	60.13	4.00
5.00	Subtotal wage-related costs (see inst.)	17.52	5.00
6.00	Total (sum of lines 3 thru 5)	38.28	6.00
7.00	Total overhead cost (see instructions)	34.25	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet S-3 Part IV Date/Time Prepared: 1/24/2013 9:31 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	4,118	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	247,886	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	27	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	3,002	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)	3,916	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	82,897	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	270,514	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	78,629	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	9,608	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	700,597	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142014

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

Worksheet A
Date/Time Prepared:
1/24/2013 9:31 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		1,201,446	1,201,446	132,762	1,334,208	1.00
2.00	00200		620,998	620,998	17,896	638,894	2.00
3.00	00300		150,658	150,658	-150,658	0	3.00
4.00	00400	4,278	720,837	725,115	0	725,115	4.00
5.00	00500	756,840	1,261,123	2,017,963	0	2,017,963	5.00
7.00	00700	107,140	703,242	810,382	0	810,382	7.00
8.00	00800	0	45,636	45,636	0	45,636	8.00
9.00	00900	0	274,151	274,151	0	274,151	9.00
10.00	01000	0	371,524	371,524	0	371,524	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	578,272	24,789	603,061	0	603,061	13.00
14.00	01400	72,212	13,937	86,149	0	86,149	14.00
15.00	01500	0	473,011	473,011	0	473,011	15.00
16.00	01600	185,861	39,092	224,953	0	224,953	16.00
17.00	01700	138,227	28,742	166,969	-9,884	157,085	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,612,538	1,270,895	2,883,433	0	2,883,433	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,674	97,590	100,264	0	100,264	50.00
54.00	05400	74,820	76,786	151,606	0	151,606	54.00
60.00	06000	0	138,930	138,930	0	138,930	60.00
65.00	06500	473,023	5,193	478,216	0	478,216	65.00
66.00	06600	0	405,146	405,146	0	405,146	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	324,424	324,424	0	324,424	71.00
73.00	07300	0	528,621	528,621	0	528,621	73.00
74.00	07400	0	82,866	82,866	0	82,866	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	05950	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		4,005,885	8,859,637	12,865,522	-9,884	12,855,638	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	9,884	9,884	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		4,005,885	8,859,637	12,865,522	0	12,865,522	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142014

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

Worksheet A
Date/Time Prepared:
1/24/2013 9:31 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,903	1,331,305	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-93,231	545,663	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	-651	724,464	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	371,227	2,389,190	5.00
7.00	00700	OPERATION OF PLANT	-387	809,995	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	45,636	8.00
9.00	00900	HOUSEKEEPING	0	274,151	9.00
10.00	01000	DIETARY	-16,182	355,342	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	603,061	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	86,149	14.00
15.00	01500	PHARMACY	0	473,011	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-452	224,501	16.00
17.00	01700	SOCIAL SERVICE	0	157,085	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-762,434	2,120,999	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	100,264	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	151,606	54.00
60.00	06000	LABORATORY	2,427	141,357	60.00
65.00	06500	RESPIRATORY THERAPY	0	478,216	65.00
66.00	06600	PHYSICAL THERAPY	-21,942	383,204	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	324,424	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	528,621	73.00
74.00	07400	RENAL DIALYSIS	0	82,866	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-524,528	12,331,110	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	9,884	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)	-524,528	12,340,994	200.00

Provider CCN: 142014

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

Worksheet A-6
Date/Time Prepared:
1/24/2013 9:31 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	8,183	1,701	1.00
TOTALS				8,183	1,701	
500.00	Grand Total: Increases			8,183	1,701	500.00

Provider CCN: 142014

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

Worksheet A-6
Date/Time Prepared:
1/24/2013 9:31 am

		Decreases				Wkst. A-7 Ref.	
Cost Center		Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
A - RECLASS NON ALLOWABLE CASE MANAGER							
1.00	SOCIAL SERVICE	17.00	8,183	1,701	0		1.00
	TOTALS		8,183	1,701			
500.00	Grand Total: Decreases		8,183	1,701			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142014

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/24/2013 9:31 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	865,944	0	0	0	0	1.00
2.00	Land Improvements	10,963	661	0	661	0	2.00
3.00	Buildings and Fixtures	21,004,507	138,708	0	138,708	0	3.00
4.00	Building Improvements	3,179	41,958	0	41,958	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	2,963,232	11,178	0	11,178	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,847,825	192,505	0	192,505	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,847,825	192,505	0	192,505	0	10.00
SUMMARY OF CAPITAL							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,201,446	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	498,728	122,270	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,700,174	122,270	0	0	0	3.00
COMPUTATION OF RATIOS							
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	22,065,920	0	22,065,920	0.881215	26,250	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,974,410	0	2,974,410	0.118785	3,538	2.00
3.00	Total (sum of lines 1-2)	25,040,330	0	25,040,330	1.000000	29,788	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142014

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/24/2013 9:31 am

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	865,944	0			1.00
2.00	Land Improvements	11,624	0			2.00
3.00	Buildings and Fixtures	21,143,215	0			3.00
4.00	Building Improvements	45,137	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	2,974,410	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	25,040,330	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	25,040,330	0			10.00
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,201,446			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	620,998			2.00
3.00	Total (sum of lines 1-2)	0	1,822,444			3.00
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	106,512	0	132,762	1,203,756	0
2.00	CAP REL COSTS-MVBLE EQUIP	14,358	0	17,896	405,497	122,270
3.00	Total (sum of lines 1-2)	120,870	0	150,658	1,609,253	122,270

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142014

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	21,037	106,512	0	1,331,305	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,538	14,358	0	545,663	2.00
3.00	Total (sum of lines 1-2)	0	24,575	120,870	0	1,876,968	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 142014

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

Worksheet A-8

Date/Time Prepared:
1/24/2013 9:31 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
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	-336	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	-13,650	ADMINISTRATIVE & GENERAL	5.00 7.00
8.00 Television and radio service (chapter 21)	A	-387	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	-760,007		10.00 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	99,044		12.00 12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests	B	-14,067	DIETARY	10.00 14.00
15.00 Rental of quarters to employee and others		0		0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00 Sale of drugs to other than patients		0		0.00 17.00
18.00 Sale of medical records and abstracts	B	-452	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00 Vending machines	B	-2,115	DIETARY	10.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)			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	-1,071	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	-6,318	ADMINISTRATIVE & GENERAL	5.00 33.05
33.06		0		0.00 33.06
33.07		0		0.00 33.07
33.08 MEDICARE BAD DEBT - PART A	A	-138,908	ADMINISTRATIVE & GENERAL	5.00 33.08
33.09		0		0.00 33.09
33.10 OTHER MEDICARE NON ALLOWABLE	A	-17,962	ADMINISTRATIVE & GENERAL	5.00 33.10
33.11		0		0.00 33.11
33.12 OTHER OPERATING - PUBLIC RELATIONS	A	-299	ADMINISTRATIVE & GENERAL	5.00 33.12
33.13 OTHER OPERATING - MARKETING	A	-12,806	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	-317	ADMINISTRATIVE & GENERAL	5.00 33.20
33.21		0		0.00 33.21

ADJUSTMENTS TO EXPENSES

Provider CCN: 142014

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

Worksheet A-8

Date/Time Prepared:
1/24/2013 9:31 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	-8,666	ADMINISTRATIVE & GENERAL	5.00	33.23
33.24		0		0.00	33.24
33.25		0		0.00	33.25
33.26		0		0.00	33.26
33.27	A	960	ADMINISTRATIVE & GENERAL	5.00	33.27
33.28	A	22,790	ADMINISTRATIVE & GENERAL	5.00	33.28
33.29	A	-3,744	ADMINISTRATIVE & GENERAL	5.00	33.29
33.30		0		0.00	33.30
33.31		0		0.00	33.31
33.32		0		0.00	33.32
33.33		0		0.00	33.33
33.34	A	28,777	ADMINISTRATIVE & GENERAL	5.00	33.34
33.35	A	8,313	ADMINISTRATIVE & GENERAL	5.00	33.35
33.36		0		0.00	33.36
33.37	A	-930	ADMINISTRATIVE & GENERAL	5.00	33.37
33.38	A	-5,823	CAP REL COSTS-BLDG & FIXT	1.00	33.38
33.39	A	-96,716	CAP REL COSTS-MVBLE EQUIP	2.00	33.39
33.40	A	8,133	CAP REL COSTS-BLDG & FIXT	1.00	33.40
33.41	A	11,178	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	-4,238	ADMINISTRATIVE & GENERAL	5.00	33.44
33.45		0		0.00	33.45
33.46	A	-5,213	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	A	-7,693	CAP REL COSTS-MVBLE EQUIP	2.00	33.52
33.53	A	402,398	ADMINISTRATIVE & GENERAL	5.00	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	-3,752	ADMINISTRATIVE & GENERAL	5.00	33.60
33.61	A	-651	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	-3,869	ADULTS & PEDIATRICS	30.00	33.74
33.75		0		0.00	33.75
33.76		0		0.00	33.76
33.77		0		0.00	33.77
33.78		0		0.00	33.78
33.79	A	3,869	LABORATORY	60.00	33.79
33.80		0		0.00	33.80
33.81		0		0.00	33.81
33.82		0		0.00	33.82
33.83		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		0		0.00	33.89
33.90		0		0.00	33.90

ADJUSTMENTS TO EXPENSES

Provider CCN: 142014

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

Worksheet A-8

Date/Time Prepared:
1/24/2013 9:31 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
33.91		0			0.00	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.)	-524,528				50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 142014

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

Worksheet A-8

Date/Time Prepared:
1/24/2013 9:31 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		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		0	33.11
33.12	OTHER OPERATING - PUBLIC RELATIONS	0	33.12
33.13	OTHER OPERATING - MARKETING	0	33.13
33.14		0	33.14
33.15		0	33.15
33.16		0	33.16
33.17		0	33.17
33.18		0	33.18
33.19		0	33.19
33.20	OTHER OPERATING - TRADE SHOW BOOTH	0	33.20
33.21		0	33.21
33.22		0	33.22
33.23	CHARITABLE CONTRIBUTIONS	0	33.23
33.24		0	33.24
33.25		0	33.25
33.26		0	33.26
33.27	MALPRACTICE FINITE COST	0	33.27

ADJUSTMENTS TO EXPENSES

Provider CCN: 142014

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

Worksheet A-8

Date/Time Prepared:
1/24/2013 9:31 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	0	33.31
33.32	0	33.32
33.33	0	33.33
33.34 MALPRACTICE TAIL LIABILITY	0	33.34
33.35 AGGREGATE CAP PYMT-NONALLOWABLE	0	33.35
33.36	0	33.36
33.37 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 PATIENT PHONE - DEPREC EQUIP	9	33.52
33.53 DEFERRED PRE OPENING COSTS	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	0	33.77
33.78	0	33.78
33.79 PHYSICIAN FEE ADJUSTMENT	0	33.79
33.80	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	0	33.89
33.90	0	33.90
33.91	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: 142014

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

Worksheet A-8-1

Date/Time Prepared:
1/24/2013 9:31 am

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	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	0.00			4.02
4.03	0.00			4.03
4.04	0.00			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. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	B	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
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: 142014

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

Worksheet A-8-1

Date/Time Prepared: 1/24/2013 9:31 am

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	697,843	576,857	120,986	0	1.00
2.00	73,479	73,479	0	0	2.00
3.00	207,975	207,975	0	0	3.00
4.00	0	0	0	0	4.00
4.01	382,264	404,206	-21,942	0	4.01
4.02	0	0	0	0	4.02
4.03	0	0	0	0	4.03
4.04	0	0	0	0	4.04
4.05	0	0	0	0	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	1,361,561	1,262,517	99,044	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
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: 142014

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

Worksheet A-8-2

Date/Time Prepared:
1/24/2013 9:31 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		0.00	DR. A	0	0	1.00
2.00		60.00	DR. B	3,869	0	2.00
3.00		30.00	DR. C	150	0	3.00
4.00		30.00	DR. D	9,500	0	4.00
5.00		30.00	DR. E	19,030	0	5.00
6.00		30.00	DR. F	25,536	25,536	6.00
7.00		30.00	DR. G	22,150	0	7.00
8.00		30.00	DR. H	7,462	0	8.00
9.00		30.00	DR. I	697,810	697,810	9.00
10.00		0.00		0	0	10.00
200.00				785,507	723,346	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 142014

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

Worksheet A-8-2

Date/Time Prepared:
1/24/2013 9:31 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	0	0	0	0	0	1.00
2.00	3,869	219,500	23	2,427	121	2.00
3.00	150	171,400	1	82	4	3.00
4.00	9,500	171,400	44	3,626	181	4.00
5.00	19,030	171,400	109	8,982	449	5.00
6.00	0	171,400	0	0	0	6.00
7.00	22,150	171,400	94	7,746	387	7.00
8.00	7,462	171,400	32	2,637	132	8.00
9.00	0	171,400	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	62,161		303	25,500	1,274	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 142014

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

Worksheet A-8-2

Date/Time Prepared:
1/24/2013 9:31 am

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	2,427	2.00
3.00	0	0	0	0	82	3.00
4.00	0	0	0	0	3,626	4.00
5.00	0	0	0	0	8,982	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	7,746	7.00
8.00	0	0	0	0	2,637	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	25,500	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 142014

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

Worksheet A-8-2
Date/Time Prepared:
1/24/2013 9:31 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	0	1.00
2.00	1,442	1,442	2.00
3.00	68	68	3.00
4.00	5,874	5,874	4.00
5.00	10,048	10,048	5.00
6.00	0	25,536	6.00
7.00	14,404	14,404	7.00
8.00	4,825	4,825	8.00
9.00	0	697,810	9.00
10.00	0	0	10.00
200.00	36,661	760,007	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142014

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

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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,331,305	1,331,305			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	545,663		545,663		2.00
4.00 00400	EMPLOYEE BENEFITS	724,464	4,905	2,010	731,379	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,389,190	117,457	48,142	138,328	5.00
7.00 00700	OPERATION OF PLANT	809,995	244,300	100,132	19,582	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	45,636	29,639	12,148	0	8.00
9.00 00900	HOUSEKEEPING	274,151	22,071	9,046	0	9.00
10.00 01000	DIETARY	355,342	69,299	28,404	0	10.00
11.00 01100	CAFETERIA	0	63,337	25,960	0	11.00
13.00 01300	NURSING ADMINISTRATION	603,061	9,302	3,813	105,691	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	86,149	84,393	34,590	13,198	14.00
15.00 01500	PHARMACY	473,011	41,647	17,070	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	224,501	15,348	6,291	33,970	16.00
17.00 01700	SOCIAL SERVICE	157,085	10,274	4,211	23,768	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,120,999	523,651	214,628	294,727	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	100,264	0	0	489	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	151,606	8,541	3,501	13,675	54.00
60.00 06000	LABORATORY	141,357	3,678	1,508	0	60.00
65.00 06500	RESPIRATORY THERAPY	478,216	18,477	7,573	86,455	65.00
66.00 06600	PHYSICAL THERAPY	383,204	37,461	15,354	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	324,424	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	528,621	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	82,866	27,525	11,282	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09800	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,331,110	1,331,305	545,663	729,883	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CASE MANAGER	9,884	0	0	1,496	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07 07957	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		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	12,340,994	1,331,305	545,663	731,379	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142014

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

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,693,117					5.00
7.00	00700	OPERATION OF PLANT	327,714	1,501,723				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,403	46,141	157,967			8.00
9.00	00900	HOUSEKEEPING	85,213	34,359	0	424,840		9.00
10.00	01000	DIETARY	126,463	107,882	0	32,249	719,639	10.00
11.00	01100	CAFETERIA	24,926	98,601	0	29,474	253,895	11.00
13.00	01300	NURSING ADMINISTRATION	201,503	14,481	0	4,329	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	60,945	131,380	0	39,273	0	14.00
15.00	01500	PHARMACY	148,427	64,834	0	19,381	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	78,190	23,893	0	7,142	0	16.00
17.00	01700	SOCIAL SERVICE	54,527	15,995	0	4,781	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	880,412	815,203	157,967	243,684	452,815	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	28,124	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,498	13,296	0	3,975	0	54.00
60.00	06000	LABORATORY	40,906	5,726	0	1,712	0	60.00
65.00	06500	RESPIRATORY THERAPY	164,894	28,764	0	8,598	0	65.00
66.00	06600	PHYSICAL THERAPY	121,711	58,318	0	17,433	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	90,560	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	147,560	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	33,964	42,850	0	12,809	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09900	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,689,940	1,501,723	157,967	424,840	706,710	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	3,177	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	0	194.06
194.07	07957	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	12,929	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)	2,693,117	1,501,723	157,967	424,840	719,639	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142014

Period:
From 09/01/2011
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	496,193					11.00
13.00	01300	63,152	1,005,332				13.00
14.00	01400	18,043	0	467,971			14.00
15.00	01500	0	0	5,423	769,793		15.00
16.00	01600	27,065	0	36	0	416,436	16.00
17.00	01700	18,043	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	288,694	1,005,332	4,768	13,544	138,071	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	4,469	50.00
54.00	05400	9,022	0	940	0	5,661	54.00
60.00	06000	0	0	767	0	27,046	60.00
65.00	06500	72,174	0	2,128	0	59,479	65.00
66.00	06600	0	0	541	0	19,761	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	453,362	0	33,049	71.00
73.00	07300	0	0	0	756,249	125,516	73.00
74.00	07400	0	0	6	0	3,384	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	05950	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		496,193	1,005,332	467,971	769,793	416,436	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		496,193	1,005,332	467,971	769,793	416,436	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142014

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

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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	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	288,684			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	288,684	7,443,179	0	7,443,179	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	133,346	0	133,346	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	259,715	0	259,715	54.00
60.00	06000	LABORATORY	0	222,700	0	222,700	60.00
65.00	06500	RESPIRATORY THERAPY	0	926,758	0	926,758	65.00
66.00	06600	PHYSICAL THERAPY	0	653,783	0	653,783	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	901,395	0	901,395	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,557,946	0	1,557,946	73.00
74.00	07400	RENAL DIALYSIS	0	214,686	0	214,686	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	288,684	12,313,508	0	12,313,508	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	14,557	0	14,557	194.00
194.01	07951	IDLE SPACE	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07	07957	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	12,929	0	12,929	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)	288,684	12,340,994	0	12,340,994	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 142014

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	4,905	2,010	6,915	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	77,146	117,457	48,142	242,745	5.00
7.00 00700	OPERATION OF PLANT	0	244,300	100,132	344,432	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	29,639	12,148	41,787	8.00
9.00 00900	HOUSEKEEPING	0	22,071	9,046	31,117	9.00
10.00 01000	DIETARY	0	69,299	28,404	97,703	10.00
11.00 01100	CAFETERIA	0	63,337	25,960	89,297	11.00
13.00 01300	NURSING ADMINISTRATION	0	9,302	3,813	13,115	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	84,393	34,590	118,983	14.00
15.00 01500	PHARMACY	0	41,647	17,070	58,717	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	15,348	6,291	21,639	16.00
17.00 01700	SOCIAL SERVICE	0	10,274	4,211	14,485	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	523,651	214,628	738,279	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	8,541	3,501	12,042	54.00
60.00 06000	LABORATORY	0	3,678	1,508	5,186	60.00
65.00 06500	RESPIRATORY THERAPY	0	18,477	7,573	26,050	65.00
66.00 06600	PHYSICAL THERAPY	0	37,461	15,354	52,815	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	0	27,525	11,282	38,807	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	77,146	1,331,305	545,663	1,954,114	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CASE MANAGER	0	0	0	0	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0	194.06
194.07 07957	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				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	77,146	1,331,305	545,663	1,954,114	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 142014

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

Worksheet B
Part II
Date/Time Prepared:
1/24/2013 9:31 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	244,053					5.00
7.00	00700	29,698	374,315				7.00
8.00	00800	2,211	11,501	55,499			8.00
9.00	00900	7,722	8,564	0	47,403		9.00
10.00	01000	11,460	26,890	0	3,598	139,651	10.00
11.00	01100	2,259	24,577	0	3,289	49,270	11.00
13.00	01300	18,260	3,609	0	483	0	13.00
14.00	01400	5,523	32,747	0	4,382	0	14.00
15.00	01500	13,451	16,160	0	2,162	0	15.00
16.00	01600	7,086	5,956	0	797	0	16.00
17.00	01700	4,941	3,987	0	533	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	79,782	203,196	55,499	27,192	87,872	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,549	0	0	0	0	50.00
54.00	05400	4,486	3,314	0	443	0	54.00
60.00	06000	3,707	1,427	0	191	0	60.00
65.00	06500	14,943	7,170	0	959	0	65.00
66.00	06600	11,030	14,536	0	1,945	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	8,207	0	0	0	0	71.00
73.00	07300	13,372	0	0	0	0	73.00
74.00	07400	3,078	10,681	0	1,429	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09800	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		243,765	374,315	55,499	47,403	137,142	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	288	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	2,509	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		244,053	374,315	55,499	47,403	139,651	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 142014

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

Worksheet B
Part II
Date/Time Prepared:
1/24/2013 9:31 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	168,692					11.00
13.00	01300	21,470	57,936				13.00
14.00	01400	6,134	0	167,894			14.00
15.00	01500	0	0	1,946	92,436		15.00
16.00	01600	9,201	0	13	0	45,013	16.00
17.00	01700	6,134	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	98,149	57,936	1,711	1,626	14,920	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	483	50.00
54.00	05400	3,067	0	337	0	612	54.00
60.00	06000	0	0	275	0	2,924	60.00
65.00	06500	24,537	0	764	0	6,430	65.00
66.00	06600	0	0	194	0	2,136	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	162,652	0	3,573	71.00
73.00	07300	0	0	0	90,810	13,569	73.00
74.00	07400	0	0	2	0	366	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	05950	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		168,692	57,936	167,894	92,436	45,013	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		168,692	57,936	167,894	92,436	45,013	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet B Part II Date/Time Prepared: 1/24/2013 9:31 am
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	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	30,305			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,305	1,399,254	0	1,399,254
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,037	0	3,037
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,430	0	24,430
60.00	06000	LABORATORY	0	13,710	0	13,710
65.00	06500	RESPIRATORY THERAPY	0	81,670	0	81,670
66.00	06600	PHYSICAL THERAPY	0	82,656	0	82,656
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	174,432	0	174,432
73.00	07300	DRUGS CHARGED TO PATIENTS	0	117,751	0	117,751
74.00	07400	RENAL DIALYSIS	0	54,363	0	54,363
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,305	1,951,303	0	1,951,303
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	0	302	0	302
194.01	07951	IDLE SPACE	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	0
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0
194.09	07958	VISITOR MEALS	0	2,509	0	2,509
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	30,305	1,954,114	0	1,954,114

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142014

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

Worksheet B-1
Date/Time Prepared:
1/24/2013 9:31 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					
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT	31,487					1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP		31,487				2.00	
4.00 00400 EMPLOYEE BENEFITS	116	116	4,001,607			4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	2,778	2,778	756,840	-2,693,117	9,647,877	5.00	
7.00 00700 OPERATION OF PLANT	5,778	5,778	107,140	0	1,174,009	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	701	701	0	0	87,423	8.00	
9.00 00900 HOUSEKEEPING	522	522	0	0	305,268	9.00	
10.00 01000 DIETARY	1,639	1,639	0	0	453,045	10.00	
11.00 01100 CAFETERIA	1,498	1,498	0	0	89,297	11.00	
13.00 01300 NURSING ADMINISTRATION	220	220	578,272	0	721,867	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	1,996	1,996	72,212	0	218,330	14.00	
15.00 01500 PHARMACY	985	985	0	0	531,728	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	363	363	185,861	0	280,110	16.00	
17.00 01700 SOCIAL SERVICE	243	243	130,044	0	195,338	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	12,385	12,385	1,612,538	0	3,154,005	30.00	
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	2,674	0	100,753	50.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	202	202	74,820	0	177,323	54.00	
60.00 06000 LABORATORY	87	87	0	0	146,543	60.00	
65.00 06500 RESPIRATORY THERAPY	437	437	473,023	0	590,721	65.00	
66.00 06600 PHYSICAL THERAPY	886	886	0	0	436,019	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	324,424	71.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	528,621	73.00	
74.00 07400 RENAL DIALYSIS	651	651	0	0	121,673	74.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
91.00 09100 EMERGENCY	0	0	0	0	0	91.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00	
98.00 09950 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	31,487	31,487	3,993,424	-2,693,117	9,636,497	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
194.00 07950 NONALLOWABLE CASE MANAGER	0	0	8,183	0	11,380	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	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,331,305	545,663	731,379	2,693,117	202.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	42.281100	17.329787	0.182771	0.279141	203.00	
204.00	Cost to be allocated (per Wkst. B, Part II)			6,915	244,053	204.00	
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001728	0.025296	205.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142014

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

Worksheet B-1

Date/Time Prepared:
1/24/2013 9:31 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	22,815				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	701	5,841			8.00
9.00	00900	HOUSEKEEPING	522	0	21,592		9.00
10.00	01000	DIETARY	1,639	0	1,639	19,203	10.00
11.00	01100	CAFETERIA	1,498	0	1,498	6,775	55
13.00	01300	NURSING ADMINISTRATION	220	0	220	0	7
14.00	01400	CENTRAL SERVICES & SUPPLY	1,996	0	1,996	0	2
15.00	01500	PHARMACY	985	0	985	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	363	0	363	0	3
17.00	01700	SOCIAL SERVICE	243	0	243	0	2
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,385	5,841	12,385	12,083	32
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	202	0	202	0	1
60.00	06000	LABORATORY	87	0	87	0	0
65.00	06500	RESPIRATORY THERAPY	437	0	437	0	8
66.00	06600	PHYSICAL THERAPY	886	0	886	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	651	0	651	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09500	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,815	5,841	21,592	18,858	55
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	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	345	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)	1,501,723	157,967	424,840	719,639	496,193
203.00		Unit cost multiplier (Wkst. B, Part I)	65.821740	27.044513	19.675806	37.475342	9,021.690909
204.00		Cost to be allocated (per Wkst. B, Part II)	374,315	55,499	47,403	139,651	168,692
205.00		Unit cost multiplier (Wkst. B, Part II)	16.406531	9.501626	2.195396	7.272353	3,067.127273

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142014

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

Worksheet B-1
Date/Time Prepared:
1/24/2013 9:31 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	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	32					13.00
14.00	01400	0	334,879				14.00
15.00	01500	0	3,881	538,088			15.00
16.00	01600	0	26	0	27,267,599		16.00
17.00	01700	0	0	0	0	5,841	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	32	3,412	9,467	9,040,491	5,841	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	292,647	0	50.00
54.00	05400	0	673	0	370,656	0	54.00
60.00	06000	0	549	0	1,770,946	0	60.00
65.00	06500	0	1,523	0	3,894,627	0	65.00
66.00	06600	0	387	0	1,293,953	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	324,424	0	2,164,023	0	71.00
73.00	07300	0	0	528,621	8,218,681	0	73.00
74.00	07400	0	4	0	221,575	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09800	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		32	334,879	538,088	27,267,599	5,841	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00							201.00
202.00		1,005,332	467,971	769,793	416,436	288,684	202.00
203.00		31,416.625000	1.397433	1.430608	0.015272	49.423729	203.00
204.00		57,936	167,894	92,436	45,013	30,305	204.00
205.00		1,810.500000	0.501357	0.171786	0.001651	5.188324	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	7,443,179		7,443,179	35,219	7,478,398	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	133,346		133,346	0	133,346	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	259,715		259,715	0	259,715	54.00
60.00	06000 LABORATORY	222,700		222,700	1,442	224,142	60.00
65.00	06500 RESPIRATORY THERAPY	926,758	0	926,758	0	926,758	65.00
66.00	06600 PHYSICAL THERAPY	653,783	0	653,783	0	653,783	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	901,395		901,395	0	901,395	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,557,946		1,557,946	0	1,557,946	73.00
74.00	07400 RENAL DIALYSIS	214,686		214,686	0	214,686	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00	Subtotal (see instructions)	12,313,508	0	12,313,508	36,661	12,350,169	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	12,313,508	0	12,313,508	36,661	12,350,169	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142014

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		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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,040,491		9,040,491			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	292,647	0	292,647	0.455655	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	370,656	0	370,656	0.700690	0.000000	54.00
60.00	06000	LABORATORY	1,770,946	0	1,770,946	0.125752	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,894,627	0	3,894,627	0.237958	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,293,953	0	1,293,953	0.505260	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	2,164,023	0	2,164,023	0.416537	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,218,681	0	8,218,681	0.189562	0.000000	73.00
74.00	07400	RENAL DIALYSIS	221,575	0	221,575	0.968909	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
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
OTHER REIMBURSABLE COST CENTERS								
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)	27,267,599	0	27,267,599			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	27,267,599	0	27,267,599			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.455655			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.700690			54.00
60.00	06000 LABORATORY	0.126566			60.00
65.00	06500 RESPIRATORY THERAPY	0.237958			65.00
66.00	06600 PHYSICAL THERAPY	0.505260			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	0.416537			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.189562			73.00
74.00	07400 RENAL DIALYSIS	0.968909			74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
98.00	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

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		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	7,443,179		7,443,179	35,219	7,478,398	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	133,346		133,346	0	133,346	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	259,715		259,715	0	259,715	54.00
60.00	06000 LABORATORY	222,700		222,700	1,442	224,142	60.00
65.00	06500 RESPIRATORY THERAPY	926,758	0	926,758	0	926,758	65.00
66.00	06600 PHYSICAL THERAPY	653,783	0	653,783	0	653,783	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	901,395		901,395	0	901,395	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,557,946		1,557,946	0	1,557,946	73.00
74.00	07400 RENAL DIALYSIS	214,686		214,686	0	214,686	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00	Subtotal (see instructions)	12,313,508	0	12,313,508	36,661	12,350,169	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	12,313,508	0	12,313,508	36,661	12,350,169	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

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		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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,040,491		9,040,491			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	292,647	0	292,647	0.455655	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	370,656	0	370,656	0.700690	0.000000	54.00
60.00	06000	LABORATORY	1,770,946	0	1,770,946	0.125752	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,894,627	0	3,894,627	0.237958	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,293,953	0	1,293,953	0.505260	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	2,164,023	0	2,164,023	0.416537	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,218,681	0	8,218,681	0.189562	0.000000	73.00
74.00	07400	RENAL DIALYSIS	221,575	0	221,575	0.968909	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
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
OTHER REIMBURSABLE COST CENTERS								
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)	27,267,599	0	27,267,599			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	27,267,599	0	27,267,599			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.455655			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.700690			54.00
60.00	06000 LABORATORY	0.126566			60.00
65.00	06500 RESPIRATORY THERAPY	0.237958			65.00
66.00	06600 PHYSICAL THERAPY	0.505260			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	0.416537			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.189562			73.00
74.00	07400 RENAL DIALYSIS	0.968909			74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
98.00	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

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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	7,443,179		7,443,179	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
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	133,346		133,346	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	259,715		259,715	0	0	54.00
60.00	06000 LABORATORY	222,700		222,700	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	926,758	0	926,758	0	0	65.00
66.00	06600 PHYSICAL THERAPY	653,783	0	653,783	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	901,395		901,395	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,557,946		1,557,946	0	0	73.00
74.00	07400 RENAL DIALYSIS	214,686		214,686	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00	Subtotal (see instructions)	12,313,508	0	12,313,508	0	0	200.00
201.00	Less Observation Beds	0		0			201.00
202.00	Total (see instructions)	12,313,508	0	12,313,508	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

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		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,040,491		9,040,491		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	292,647	0	292,647	0.455655	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	370,656	0	370,656	0.700690	54.00
60.00	06000	LABORATORY	1,770,946	0	1,770,946	0.125752	60.00
65.00	06500	RESPIRATORY THERAPY	3,894,627	0	3,894,627	0.237958	65.00
66.00	06600	PHYSICAL THERAPY	1,293,953	0	1,293,953	0.505260	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,164,023	0	2,164,023	0.416537	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,218,681	0	8,218,681	0.189562	73.00
74.00	07400	RENAL DIALYSIS	221,575	0	221,575	0.968909	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
200.00		Subtotal (see instructions)	27,267,599	0	27,267,599		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	27,267,599	0	27,267,599		202.00

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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
98.00	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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 142014

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

Worksheet C Part II Date/Time Prepared: 1/24/2013 9:31 am

Cost Center Description		Title XIX			Hospital		Operating Cost Reduction Amount	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	133,346	3,037	130,309	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	259,715	24,430	235,285	0	0	54.00
60.00	06000	LABORATORY	222,700	13,710	208,990	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	926,758	81,670	845,088	0	0	65.00
66.00	06600	PHYSICAL THERAPY	653,783	82,656	571,127	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	901,395	174,432	726,963	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,557,946	117,751	1,440,195	0	0	73.00
74.00	07400	RENAL DIALYSIS	214,686	54,363	160,323	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Subtotal (sum of lines 50 thru 199)	4,870,329	552,049	4,318,280	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	4,870,329	552,049	4,318,280	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 142014

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

Worksheet C Part II Date/Time Prepared: 1/24/2013 9:31 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Cost
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	133,346	292,647	0.455655	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	259,715	370,656	0.700690	54.00
60.00	06000 LABORATORY	222,700	1,770,946	0.125752	60.00
65.00	06500 RESPIRATORY THERAPY	926,758	3,894,627	0.237958	65.00
66.00	06600 PHYSICAL THERAPY	653,783	1,293,953	0.505260	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	901,395	2,164,023	0.416537	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,557,946	8,218,681	0.189562	73.00
74.00	07400 RENAL DIALYSIS	214,686	221,575	0.968909	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	98.00
200.00	Subtotal (sum of lines 50 thru 199)	4,870,329	18,227,108		200.00
201.00	Less Observation Beds	0	0		201.00
202.00	Total (line 200 minus line 201)	4,870,329	18,227,108		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 142014		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part I Date/Time Prepared: 1/24/2013 9:31 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	1,399,254	0	1,399,254	5,841	239.56 30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0.00 31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0.00 44.00
200.00		Total (lines 30-199)	1,399,254		1,399,254	5,841	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part I Date/Time Prepared: 1/24/2013 9:31 am
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
			6.00	7.00	
Title XVIII Hospital PPS					
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,566	854,271	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)	3,566	854,271	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part II Date/Time Prepared: 1/24/2013 9:31 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,037	292,647	0.010378	191,721	1,990	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	24,430	370,656	0.065910	222,525	14,667	54.00
60.00	06000 LABORATORY	13,710	1,770,946	0.007742	1,203,923	9,321	60.00
65.00	06500 RESPIRATORY THERAPY	81,670	3,894,627	0.020970	2,296,360	48,155	65.00
66.00	06600 PHYSICAL THERAPY	82,656	1,293,953	0.063879	797,946	50,972	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	174,432	2,164,023	0.080605	1,365,238	110,045	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	117,751	8,218,681	0.014327	5,376,845	77,034	73.00
74.00	07400 RENAL DIALYSIS	54,363	221,575	0.245348	161,854	39,711	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (Lines 50-199)	552,049	18,227,108		11,616,412	351,895	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142014		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part III Date/Time Prepared: 1/24/2013 9:31 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: 142014		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part III Date/Time Prepared: 1/24/2013 9:31 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	5,841	0.00	3,566	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)	5,841		3,566	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142014

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

Worksheet D
Part IV
Date/Time Prepared:
1/24/2013 9:31 am

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	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	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES						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: 142014

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

Worksheet D
Part IV
Date/Time Prepared:
1/24/2013 9:31 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII			Hospital		Inpatient Program Charges	
			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)	PPS			
		6.00	7.00	8.00	9.00	10.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	292,647	0.000000	0.000000	191,721	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	370,656	0.000000	0.000000	222,525	54.00	
60.00	06000	LABORATORY	0	1,770,946	0.000000	0.000000	1,203,923	60.00	
65.00	06500	RESPIRATORY THERAPY	0	3,894,627	0.000000	0.000000	2,296,360	65.00	
66.00	06600	PHYSICAL THERAPY	0	1,293,953	0.000000	0.000000	797,946	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	2,164,023	0.000000	0.000000	1,365,238	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,218,681	0.000000	0.000000	5,376,845	73.00	
74.00	07400	RENAL DIALYSIS	0	221,575	0.000000	0.000000	161,854	74.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00	
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00	
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00	
200.00		Total (Lines 50-199)	0	18,227,108			11,616,412	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142014

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

Worksheet D
Part IV
Date/Time Prepared:
1/24/2013 9:31 am

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		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	9,469	0		54.00
60.00	06000 LABORATORY	0	392	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	14,132	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	286	0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	16,394	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00	Total (Lines 50-199)	0	40,673	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part V Date/Time Prepared: 1/24/2013 9:31 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	0.455655	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.700690	9,469	0	0	0	54.00
60.00	06000	LABORATORY	0.125752	392	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.237958	14,132	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.505260	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.416537	286	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.189562	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.968909	16,394	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		40,673	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		40,673	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part V Date/Time Prepared: 1/24/2013 9:31 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				
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,635	0	0	54.00
60.00	06000	LABORATORY	49	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,363	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	119	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	15,884	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		0		95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
200.00		Subtotal (see instructions)	26,050	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	26,050	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 142014		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part I Date/Time Prepared: 1/24/2013 9:31 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	1,399,254	0	1,399,254	5,841	239.56	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00		Total (lines 30-199)	1,399,254		1,399,254	5,841		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part I Date/Time Prepared: 1/24/2013 9:31 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	3,566	854,271	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)	3,566	854,271	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part II Date/Time Prepared: 1/24/2013 9:31 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,037	292,647	0.010378	191,721	1,990	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	24,430	370,656	0.065910	222,525	14,667	54.00
60.00	06000 LABORATORY	13,710	1,770,946	0.007742	1,203,923	9,321	60.00
65.00	06500 RESPIRATORY THERAPY	81,670	3,894,627	0.020970	2,296,360	48,155	65.00
66.00	06600 PHYSICAL THERAPY	82,656	1,293,953	0.063879	797,946	50,972	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	174,432	2,164,023	0.080605	1,365,238	110,045	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	117,751	8,218,681	0.014327	5,376,845	77,034	73.00
74.00	07400 RENAL DIALYSIS	54,363	221,575	0.245348	161,854	39,711	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (Lines 50-199)	552,049	18,227,108		11,616,412	351,895	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142014		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part III Date/Time Prepared: 1/24/2013 9:31 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: 142014		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part III Date/Time Prepared: 1/24/2013 9:31 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	5,841	0.00	3,566	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)	5,841		3,566	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142014

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

Worksheet D
Part IV
Date/Time Prepared:
1/24/2013 9:31 am

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142014

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

Worksheet D
Part IV
Date/Time Prepared:
1/24/2013 9:31 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII			Hospital		Inpatient Program Charges	
			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)	PPS			
		6.00	7.00	8.00	9.00	10.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	292,647	0.000000	0.000000	191,721	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	370,656	0.000000	0.000000	222,525	54.00	
60.00	06000	LABORATORY	0	1,770,946	0.000000	0.000000	1,203,923	60.00	
65.00	06500	RESPIRATORY THERAPY	0	3,894,627	0.000000	0.000000	2,296,360	65.00	
66.00	06600	PHYSICAL THERAPY	0	1,293,953	0.000000	0.000000	797,946	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	2,164,023	0.000000	0.000000	1,365,238	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,218,681	0.000000	0.000000	5,376,845	73.00	
74.00	07400	RENAL DIALYSIS	0	221,575	0.000000	0.000000	161,854	74.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00	
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00	
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00	
200.00		Total (Lines 50-199)	0	18,227,108			11,616,412	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142014

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

Worksheet D
Part IV
Date/Time Prepared:
1/24/2013 9:31 am

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		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	9,469	0		54.00
60.00	06000 LABORATORY	0	392	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	14,132	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	286	0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	16,394	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00	Total (Lines 50-199)	0	40,673	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part V Date/Time Prepared: 1/24/2013 9:31 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	0.455655	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.700690	9,469	0	0		54.00
60.00	06000	LABORATORY	0.125752	392	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.237958	14,132	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.505260	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	0.416537	286	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.189562	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0.968909	16,394	0	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)		40,673	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		40,673	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part V Date/Time Prepared: 1/24/2013 9:31 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				
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,635	0	0	54.00
60.00	06000	LABORATORY	49	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,363	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	119	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	15,884	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		0		95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
200.00		Subtotal (see instructions)	26,050	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	26,050	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 142014		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part I Date/Time Prepared: 1/24/2013 9:31 am	
Cost Center Description		Title XIX		Hospital		Cost	
		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	1,399,254	0	1,399,254	5,841	239.56 30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0.00 31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0.00 44.00
200.00		Total (lines 30-199)	1,399,254		1,399,254	5,841	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part I Date/Time Prepared: 1/24/2013 9:31 am
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
			6.00	7.00	
Title XIX Hospital Cost					
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,048	251,059	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)	1,048	251,059	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part II Date/Time Prepared: 1/24/2013 9:31 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,037	292,647	0.010378	74,422	772	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	24,430	370,656	0.065910	100,247	6,607	54.00
60.00	06000 LABORATORY	13,710	1,770,946	0.007742	276,087	2,137	60.00
65.00	06500 RESPIRATORY THERAPY	81,670	3,894,627	0.020970	800,591	16,788	65.00
66.00	06600 PHYSICAL THERAPY	82,656	1,293,953	0.063879	200,926	12,835	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	174,432	2,164,023	0.080605	332,337	26,788	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	117,751	8,218,681	0.014327	1,571,459	22,514	73.00
74.00	07400 RENAL DIALYSIS	54,363	221,575	0.245348	26,933	6,608	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (Lines 50-199)	552,049	18,227,108		3,383,002	95,049	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142014		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part III Date/Time Prepared: 1/24/2013 9:31 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: 142014		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part III Date/Time Prepared: 1/24/2013 9:31 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)	Cost	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,841	0.00	1,048	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)	5,841		1,048	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142014

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

Worksheet D
Part IV
Date/Time Prepared:
1/24/2013 9:31 am

Cost Center Description		Title XIX				Hospital		Total Cost (sum of col 1 through col 4)
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	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: 142014

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

Worksheet D
Part IV
Date/Time Prepared:
1/24/2013 9:31 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	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	292,647	0.000000	0.000000	74,422	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	370,656	0.000000	0.000000	100,247	54.00
60.00	06000 LABORATORY	0	1,770,946	0.000000	0.000000	276,087	60.00
65.00	06500 RESPIRATORY THERAPY	0	3,894,627	0.000000	0.000000	800,591	65.00
66.00	06600 PHYSICAL THERAPY	0	1,293,953	0.000000	0.000000	200,926	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	2,164,023	0.000000	0.000000	332,337	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8,218,681	0.000000	0.000000	1,571,459	73.00
74.00	07400 RENAL DIALYSIS	0	221,575	0.000000	0.000000	26,933	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00	Total (Lines 50-199)	0	18,227,108			3,383,002	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142014

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

Worksheet D
Part IV
Date/Time Prepared:
1/24/2013 9:31 am

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)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0		95.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00	Total (Lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1 Date/Time Prepared: 1/24/2013 9:31 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,841	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,841	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)		5,841	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)		3,566	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		7,478,398	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)		7,478,398	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		9,040,491	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		9,040,491	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.827211	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,547.76	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)		7,478,398	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,280.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,565,657	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)		4,565,657	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142014		Period: From 09/01/2011 To 08/31/2012		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 1/24/2013 9:31 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)		
	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	0	0	0.00	0	0		43.00
44.00							44.00
45.00							45.00
46.00							46.00
47.00							47.00
	Cost Center Description						
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,090,002	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,655,659	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)					854,271	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					351,895	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,206,166	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,449,493	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: 142014		Period: From 09/01/2011 To 08/31/2012		Worksheet D-1 Date/Time Prepared: 1/24/2013 9:31 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	1,399,254	7,478,398	0.187106	0	0	90.00
91.00	Nursing School cost	0	7,478,398	0.000000	0	0	91.00
92.00	Allied health cost	0	7,478,398	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,478,398	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1
		Title XIX		Date/Time Prepared: 1/24/2013 9:31 am
		Hospital		Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,841	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,841	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)		5,841	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)		1,048	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		7,443,179	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)		7,443,179	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		9,040,491	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		9,040,491	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.823316	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,547.76	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)		7,443,179	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,274.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,335,466	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)		1,335,466	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142014		Period: From 09/01/2011 To 08/31/2012		Worksheet D-1	
Date/Time Prepared: 1/24/2013 9:31 am		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					893,314		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,228,780		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/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: 142014

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

Worksheet D-1
Date/Time Prepared:
1/24/2013 9:31 am

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)	
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: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet D-3 Date/Time Prepared: 1/24/2013 9:31 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		5,520,560		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.455655	191,721	87,359	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.700690	222,525	155,921	54.00
60.00	06000 LABORATORY	0.126566	1,203,923	152,376	60.00
65.00	06500 RESPIRATORY THERAPY	0.237958	2,296,360	546,437	65.00
66.00	06600 PHYSICAL THERAPY	0.505260	797,946	403,170	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	0.416537	1,365,238	568,672	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.189562	5,376,845	1,019,245	73.00
74.00	07400 RENAL DIALYSIS	0.968909	161,854	156,822	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)		11,616,412	3,090,002	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)		11,616,412		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet D-3 Date/Time Prepared: 1/24/2013 9:31 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		1,640,808		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.455655	74,422	33,911	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.700690	100,247	70,242	54.00
60.00	06000 LABORATORY	0.125752	276,087	34,718	60.00
65.00	06500 RESPIRATORY THERAPY	0.237958	800,591	190,507	65.00
66.00	06600 PHYSICAL THERAPY	0.505260	200,926	101,520	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	0.416537	332,337	138,431	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.189562	1,571,459	297,889	73.00
74.00	07400 RENAL DIALYSIS	0.968909	26,933	26,096	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)		3,383,002	893,314	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)		3,383,002		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet E Part B Date/Time Prepared: 1/24/2013 9:31 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		26,050	2.00
3.00	PPS payments		11,194	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		11,194	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,548	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)		8,646	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)		8,646	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		8,646	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		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)		8,646	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)		8,646	40.00
41.00	Interim payments		8,646	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 142014

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

Worksheet E-1
Part I
Date/Time Prepared:
1/24/2013 9:31 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		4,640,107		8,646	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,640,107		8,646	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		97,236		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		4,737,343		8,646	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: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet E-3 Part IV Date/Time Prepared: 1/24/2013 9:31 am
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)			4,978,735 1.00
2.00	Outlier Payments			240,390 2.00
3.00	Total PPS Payments (sum of lines 1 and 2)			5,219,125 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)			5,219,125 7.00
8.00	Primary payer payments			79,869 8.00
9.00	Subtotal (line 7 less line 8)			5,139,256 9.00
10.00	Deductibles			6,888 10.00
11.00	Subtotal (line 9 minus line 10)			5,132,368 11.00
12.00	Coinsurance			492,261 12.00
13.00	Subtotal (line 11 minus line 12)			4,640,107 13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			138,908 14.00
15.00	Adjusted reimbursable bad debts (see instructions)			97,236 15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			138,908 16.00
17.00	Subtotal (sum of lines 13 and 15)			4,737,343 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)			4,737,343 22.00
23.00	Interim payments			4,640,107 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)			97,236 25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 26.00
TO BE COMPLETED BY CONTRACTOR				
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: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet E-3 Part IV Date/Time Prepared: 1/24/2013 9:31 am
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		4,978,735	1.00
2.00	Outlier Payments		240,390	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		5,219,125	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)		5,219,125	7.00
8.00	Primary payer payments		79,869	8.00
9.00	Subtotal (line 7 less line 8)		5,139,256	9.00
10.00	Deductibles		6,888	10.00
11.00	Subtotal (line 9 minus line 10)		5,132,368	11.00
12.00	Coinsurance		492,261	12.00
13.00	Subtotal (line 11 minus line 12)		4,640,107	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		138,908	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		97,236	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		138,908	16.00
17.00	Subtotal (sum of lines 13 and 15)		4,737,343	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)		4,737,343	22.00
23.00	Interim payments		4,640,107	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)		97,236	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
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: 142014	Period: From 09/01/2011 To 08/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 1/24/2013 9:31 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		2,228,780		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)		2,228,780	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)		2,228,780	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		1,640,808		8.00
9.00	Ancillary service charges		3,383,002	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)		5,023,810	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		5,023,810	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,795,030	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)		2,228,780	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		2,228,780	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2,228,780	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)		2,228,780	0	36.00
37.00	OTHER ADJUSTMENTS		0	0	37.00
37.01	OTHER ADJUSTMENTS		0	0	37.01
38.00	Subtotal (line 36 ± line 37)		2,228,780	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)		2,228,780	0	40.00
41.00	Interim payments		1,354,257		41.00
42.00	Balance due provider/program (line 40 minus 41)		874,523	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 142014

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

Worksheet G

Date/Time Prepared:
1/24/2013 9:31 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-46,245	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	3,526,760	0	0	0	4.00
5.00	Other receivable	11,571	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	708,159	0	0	0	6.00
7.00	Inventory	202,160	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,402,405	0	0	0	11.00
FIXED ASSETS						
12.00	Land	865,944	0	0	0	12.00
13.00	Land improvements	11,625	0	0	0	13.00
14.00	Accumulated depreciation	-1,445	0	0	0	14.00
15.00	Buildings	21,188,351	0	0	0	15.00
16.00	Accumulated depreciation	-2,086,621	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	2,974,410	0	0	0	23.00
24.00	Accumulated depreciation	-844,903	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)	22,107,361	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	26,509,766	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	659,980	0	0	0	37.00
38.00	Salaries, wages, and fees payable	328,720	0	0	0	38.00
39.00	Payroll taxes payable	10,430	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	353,032	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,352,162	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	33,083,523	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	33,083,523	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	34,435,685	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-7,925,919				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)	-7,925,919	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,509,766	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 142014

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

Worksheet G-1

Date/Time Prepared:
1/24/2013 9:31 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		-5,156,761		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-2,769,162			2.00
3.00	Total (sum of line 1 and line 2)		-7,925,923		0	3.00
4.00	Additions (credit adjustments)	0		0		4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	4		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)		4		0	10.00
11.00	Subtotal (line 3 plus line 10)		-7,925,919		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)		-7,925,919		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 142014

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

Worksheet G-1

Date/Time Prepared:
1/24/2013 9:31 am

	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: 142014

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
1/24/2013 9:31 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	9,040,491		9,040,491	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)	9,040,491		9,040,491	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)	9,040,491		9,040,491	17.00
18.00	Ancillary services	18,227,108	0	18,227,108	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)	27,267,599	0	27,267,599	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		12,865,522		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)		12,865,522		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 142014

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

Worksheet G-3

Date/Time Prepared:
1/24/2013 9:31 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	27,267,599	1.00
2.00	Less contractual allowances and discounts on patients' accounts	17,200,447	2.00
3.00	Net patient revenues (line 1 minus line 2)	10,067,152	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	12,865,522	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,798,370	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	336	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	14,985	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	452	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	2,115	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	11,320	24.00
25.00	Total other income (sum of lines 6-24)	29,208	25.00
26.00	Total (line 5 plus line 25)	-2,769,162	26.00
27.00	OTHER EXPENSES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,769,162	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

Provider CCN: 142014

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

Worksheet 1-5

Date/Time Prepared:
1/24/2013 9:31 am

		1.00	
1.00	Total expenses related to care of program beneficiaries (see instructions)	0	1.00
2.00	Total payment (from Worksheet 1-4, 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