

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: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet S Parts I-III Date/Time Prepared: 1/30/2013 1:35 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 1/30/2013 Time: 1:35 pm	
	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 St. Louis (262010) 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	84,189	26,931	0	64,412	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	84,189	26,931	0	64,412	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: 262010			Period: From 09/01/2011 To 08/31/2012		Worksheet S-2 Part I Date/Time Prepared: 1/30/2013 1:33 pm		
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 Zip Code: 63108		4.00 County: St. Louis			
1.00	Street: 4930 Lindell Boulevard	State: MO		Zip Code: 63108		County: St. Louis			
2.00	City: St. Louis								
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
		V	XVIII	XIX					
3.00	Hospital and Hospital-Based Component Identification:								
	Hospital	Kindred Hospital St. Louis	262010	41180	2	08/30/1991	N	P	O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					09/01/2011	08/31/2012		20.00
21.00	Type of Control (see instructions)					4			21.00
Inpatient PPS Information									
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00

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		Beginning: 1.00	Ending: 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
		Y/N				
		1.00				
39.00	Does this facility qualify for the Inpatient Hospital Payment Adjustment for Low Volume Hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no.					39.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for 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 trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no 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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
			1.00	2.00	3.00	
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

			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	
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	67.00

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		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			
		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		Occupational		Speech		Respiratory	
		1.00		2.00		3.00		4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N				109.00
		1.00		2.00		3.00			
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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	26,921	8,661	180,787	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
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	140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: KINDRED HEALTHCARE INC	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		Contractor's Number: 05901	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	2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

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							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
166.01							0.00	166.01
166.02							0.00	166.02
166.03							0.00	166.03
							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)							168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part II Date/Time Prepared: 1/30/2013 1:33 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/31/2013	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/31/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

		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.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
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	12/31/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
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: 262010

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

Worksheet S-3
Part I
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number		Avai lable		
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	94	34,404	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)		94	34,404	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)		94	34,404	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)		94			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: 262010

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

Worksheet S-3
Part I
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	10,140	62	19,715		1.00
2.00 HMO		739	1			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	10,140	62	19,715		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	10,140	62	19,715		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		101				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 262010

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

Worksheet S-3
Part I
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	380	1.00
2.00 HMO					25	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	205.60	0.00	0	380	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	205.60	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: 262010

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

Worksheet S-3
Part I
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	2	686		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)	2	686		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: 262010

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

Worksheet S-3
Part II
Date/Time Prepared:
1/30/2013 1:33 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	11,421,248	0	11,421,248	427,290.00	26.73
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	100,664	100,664	2,559.00	39.34
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		2,691,779	0	2,691,779	52,778.00	51.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		904,833	0	904,833	10,435.00	86.71
14.00	Home office salaries & wage-related costs		1,146,821	0	1,146,821	24,022.00	47.74
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Administrative		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		2,111,317	0	2,111,317		17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0		18.00
19.00	Excluded areas		18,774	0	18,774		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	98,522	0	98,522	3,251.00	30.31
27.00	Administrative & General	5.00	1,556,190	0	1,556,190	41,663.00	37.35
28.00	Administrative & General under contract (see inst.)		2,090	0	2,090	37.00	56.49
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	143,086	0	143,086	5,936.00	24.10
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	231,145	0	231,145	16,875.00	13.70
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	207,176	0	207,176	13,550.00	15.29
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,397,712	0	1,397,712	35,548.00	39.32
39.00	Central Services and Supply	14.00	112,188	0	112,188	6,176.00	18.17
40.00	Pharmacy	15.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 262010

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

Worksheet S-3
Part II
Date/Time Prepared:
1/30/2013 1:33 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 411,532	0	411,532	14,262.00	28.86	41.00
42.00	Social Service	17.00 662,327	-100,664	561,663	14,282.00	39.33	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 262010

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

Worksheet S-3
Part III
Date/Time Prepared:
1/30/2013 1:33 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	11,423,338	0	11,423,338	427,327.00	26.73	1.00
2.00	Excluded area salaries (see instructions)	0	100,664	100,664	2,559.00	39.34	2.00
3.00	Subtotal salaries (line 1 minus line 2)	11,423,338	-100,664	11,322,674	424,768.00	26.66	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,743,433	0	4,743,433	87,235.00	54.38	4.00
5.00	Subtotal wage-related costs (see inst.)	2,111,317	0	2,111,317	0.00	18.65	5.00
6.00	Total (sum of lines 3 thru 5)	18,278,088	-100,664	18,177,424	512,003.00	35.50	6.00
7.00	Total overhead cost (see instructions)	4,821,968	-100,664	4,721,304	151,580.00	31.15	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet S-3 Part IV Date/Time Prepared: 1/30/2013 1:33 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	14,384	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)	692,760	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	382	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	9,239	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)	43,757	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	230,795	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	814,705	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	157,003	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	148,293	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,111,318	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: 262010

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

Worksheet A
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		2,678,429	2,678,429	47,092	2,725,521	1.00
2.00	00200		609,363	609,363	187,356	796,719	2.00
3.00	00300		234,448	234,448	-234,448	0	3.00
4.00	00400	98,522	2,239,877	2,338,399	0	2,338,399	4.00
5.00	00500	1,556,190	5,504,134	7,060,324	0	7,060,324	5.00
7.00	00700	143,086	568,488	711,574	0	711,574	7.00
8.00	00800	0	143,840	143,840	0	143,840	8.00
9.00	00900	231,145	110,837	341,982	0	341,982	9.00
10.00	01000	207,176	344,942	552,118	0	552,118	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	1,397,712	11,265	1,408,977	0	1,408,977	13.00
14.00	01400	112,188	20,680	132,868	0	132,868	14.00
15.00	01500	0	1,237,859	1,237,859	0	1,237,859	15.00
16.00	01600	411,532	60,216	471,748	0	471,748	16.00
17.00	01700	662,327	90,966	753,293	-114,489	638,804	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	5,060,532	1,388,029	6,448,561	0	6,448,561	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	402,239	402,239	0	402,239	50.00
54.00	05400	73,581	382,984	456,565	0	456,565	54.00
60.00	06000	71,152	555,197	626,349	0	626,349	60.00
65.00	06500	1,396,105	70,348	1,466,453	0	1,466,453	65.00
66.00	06600	0	1,168,780	1,168,780	0	1,168,780	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	1,194,775	1,194,775	0	1,194,775	71.00
73.00	07300	0	1,993,837	1,993,837	0	1,993,837	73.00
74.00	07400	0	631,694	631,694	0	631,694	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		11,421,248	21,643,227	33,064,475	-114,489	32,949,986	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	114,489	114,489	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		11,421,248	21,643,227	33,064,475	0	33,064,475	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 262010

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

Worksheet A
Date/Time Prepared:
1/30/2013 1:33 pm

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	97,948	2,823,469	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-58,925	737,794	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	-1,941	2,336,458	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,422,511	5,637,813	5.00
7.00	00700	OPERATION OF PLANT	-1,295	710,279	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	143,840	8.00
9.00	00900	HOUSEKEEPING	0	341,982	9.00
10.00	01000	DIETARY	-8,671	543,447	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,408,977	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	132,868	14.00
15.00	01500	PHARMACY	0	1,237,859	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,323	475,071	16.00
17.00	01700	SOCIAL SERVICE	0	638,804	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-30,083	6,418,478	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	402,239	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	456,565	54.00
60.00	06000	LABORATORY	0	626,349	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,466,453	65.00
66.00	06600	PHYSICAL THERAPY	-62,946	1,105,834	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,194,775	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,993,837	73.00
74.00	07400	RENAL DIALYSIS	-2,043	629,651	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)	-1,487,144	31,462,842	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	114,489	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)	-1,487,144	31,577,331	200.00

RECLASSIFICATIONS

Provider CCN: 262010

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

Worksheet A-6

Date/Time Prepared:
1/30/2013 1:33 pm

		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	100,664	13,825	1.00
TOTALS				100,664	13,825	
500.00	Grand Total: Increases			100,664	13,825	500.00

RECLASSIFICATIONS

Provider CCN: 262010

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

Worksheet A-6

Date/Time Prepared:
1/30/2013 1:33 pm

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	100,664	13,825	0		1.00
TOTALS			100,664	13,825			
500.00	Grand Total: Decreases		100,664	13,825			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 262010

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/30/2013 1:33 pm

		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	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	2,934,164	136,650	0	136,650	1,868,816	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,555,566	226,639	0	226,639	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	7,489,730	363,289	0	363,289	1,868,816	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	7,489,730	363,289	0	363,289	1,868,816	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	64,668	2,613,761	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	353,872	255,491	0	0	0	2.00
3.00	Total (sum of lines 1-2)	418,540	2,869,252	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	1,201,998	0	1,201,998	0.200862	5,152	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,782,205	0	4,782,205	0.799138	20,498	2.00
3.00	Total (sum of lines 1-2)	5,984,203	0	5,984,203	1.000000	25,650	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 262010

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/30/2013 1:33 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	1,201,998	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	4,782,205	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	5,984,203	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	5,984,203	0			10.00
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	2,678,429			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	609,363			2.00
3.00	Total (sum of lines 1-2)	0	3,287,792			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	41,940	0	47,092	167,105	2,613,761
2.00	CAP REL COSTS-MVBLE EQUIP	166,858	0	187,356	294,947	255,491
3.00	Total (sum of lines 1-2)	208,798	0	234,448	462,052	2,869,252

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 262010

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/30/2013 1:33 pm

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	663	41,940	0	2,823,469	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	20,498	166,858	0	737,794	2.00
3.00	Total (sum of lines 1-2)	0	21,161	208,798	0	3,561,263	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 262010

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

Worksheet A-8

Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line #	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			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	-2,064	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)	B	-60	CAP REL COSTS-BLDG & FIXT		1.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-20,885	ADMINISTRATIVE & GENERAL		5.00	7.00
8.00 Television and radio service (chapter 21)	A	-1,295	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	-44,337				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	-78,098				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Cafeteria-employees and guests	B	-8,671	DIETARY		10.00	14.00
15.00 Rental of quarters to employee and others		0			0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	16.00
17.00 Sale of drugs to other than patients		0			0.00	17.00
18.00 Sale of medical records and abstracts		0			0.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	19.00
20.00 Vending machines		0			0.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			OCAP REL COSTS-BLDG & FIXT		1.00	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			OCAP REL COSTS-MVBLE EQUIP		2.00	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***		19.00	28.00
29.00 Physicians' assistant			0		0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY		67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	32.00
33.00		0			0.00	33.00
33.01 MISCELLANEOUS INCOME	B	-101,215	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	-124,285	ADMINISTRATIVE & GENERAL		5.00	33.05
33.06 PATIENT PERSONAL SERVICES EXPENSE	A	-1,460	ADMINISTRATIVE & GENERAL		5.00	33.06
33.07		0			0.00	33.07
33.08 MEDICARE BAD DEBT - PART A	A	-813,408	ADMINISTRATIVE & GENERAL		5.00	33.08
33.09		0			0.00	33.09
33.10 OTHER MEDICARE NON ALLOWABLE	A	-24,656	ADMINISTRATIVE & GENERAL		5.00	33.10
33.11 OTHER OPERATING - PATIENT RELATIONS	A	-19	ADMINISTRATIVE & GENERAL		5.00	33.11
33.12 OTHER OPERATING - PUBLIC RELATIONS	A	-668	ADMINISTRATIVE & GENERAL		5.00	33.12
33.13 OTHER OPERATING - MARKETING	A	-30,744	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 OTHER OPER - LITIGATION SETTLEMENT	A	-100	ADMINISTRATIVE & GENERAL		5.00	33.17
33.18		0			0.00	33.18
33.19 OTHER OPERATING - SPECIALTY ITEMS	A	-232	ADMINISTRATIVE & GENERAL		5.00	33.19
33.20 OTHER OPERATING - TRADE SHOW BOOTH	A	-634	ADMINISTRATIVE & GENERAL		5.00	33.20
33.21		0			0.00	33.21

ADJUSTMENTS TO EXPENSES

Provider CCN: 262010

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

Worksheet A-8

Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center	Line #	
			1.00	2.00	3.00
33.22		0		0.00	33.22
33.23	A	-5,000	ADMINISTRATIVE & GENERAL	5.00	33.23
33.24		0		0.00	33.24
33.25		0		0.00	33.25
33.26	A	-275,797	ADMINISTRATIVE & GENERAL	5.00	33.26
33.27	A	40,758	ADMINISTRATIVE & GENERAL	5.00	33.27
33.28	A	19,003	ADMINISTRATIVE & GENERAL	5.00	33.28
33.29	A	-6,003	ADMINISTRATIVE & GENERAL	5.00	33.29
33.30		0		0.00	33.30
33.31		0		0.00	33.31
33.32	A	7,100	ADMINISTRATIVE & GENERAL	5.00	33.32
33.33		0		0.00	33.33
33.34	A	11,216	ADMINISTRATIVE & GENERAL	5.00	33.34
33.35	A	8,661	ADMINISTRATIVE & GENERAL	5.00	33.35
33.36		0		0.00	33.36
33.37	A	-3,040	ADMINISTRATIVE & GENERAL	5.00	33.37
33.38	A	96,791	CAP REL COSTS-BLDG & FIXT	1.00	33.38
33.39	A	-131,622	CAP REL COSTS-MVBLE EQUIP	2.00	33.39
33.40	A	5,941	CAP REL COSTS-BLDG & FIXT	1.00	33.40
33.41	A	75,712	CAP REL COSTS-MVBLE EQUIP	2.00	33.41
33.42		0		0.00	33.42
33.43		0		0.00	33.43
33.44	A	-13,438	ADMINISTRATIVE & GENERAL	5.00	33.44
33.45		0		0.00	33.45
33.46	A	-4,489	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	-3,015	CAP REL COSTS-MVBLE EQUIP	2.00	33.52
33.53		0		0.00	33.53
33.54	A	-235	CAP REL COSTS-BLDG & FIXT	1.00	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	-10,939	ADMINISTRATIVE & GENERAL	5.00	33.60
33.61	A	-1,941	EMPLOYEE BENEFITS	4.00	33.61
33.62		0		0.00	33.62
33.63		0		0.00	33.63
33.64	A	-15,534	ADMINISTRATIVE & GENERAL	5.00	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	A	5,201	MEDICAL RECORDS & LIBRARY	16.00	33.72
33.73		0		0.00	33.73
33.74	A	-5,201	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		0		0.00	33.79
33.80	A	15,534	RESPIRATORY THERAPY	65.00	33.80
33.81		0		0.00	33.81
33.82		0		0.00	33.82
33.83		0		0.00	33.83
33.84		0		0.00	33.84
33.85		0		0.00	33.85
33.86		0		0.00	33.86
33.87		0		0.00	33.87
33.88		0		0.00	33.88
33.89	A	-43,976	ADMINISTRATIVE & GENERAL	5.00	33.89
33.90		0		0.00	33.90

Provider CCN: 262010

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

Worksheet A-8

Date/Time Prepared:
 1/30/2013 1:33 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center	Line #	
			1.00	2.00	
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.)	-1,487,144			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 262010

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

Worksheet A-8

Date/Time Prepared:
1/30/2013 1:33 pm

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)	9	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	PATIENT PERSONAL SERVICES EXPENSE	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	OTHER OPERATING - PATIENT RELATIONS	0	33.11
33.12	OTHER OPERATING - PUBLIC RELATIONS	0	33.12
33.13	OTHER OPERATING - MARKETING	0	33.13
33.14		0	33.14
33.15		0	33.15
33.16		0	33.16
33.17	OTHER OPER - LITIGATION SETTLEMENT	0	33.17
33.18		0	33.18
33.19	OTHER OPERATING - SPECIALTY ITEMS	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	OTHER OPER - PROP RESERVE ADJUST	0	33.26
33.27	MALPRACTICE FINITE COST	0	33.27

ADJUSTMENTS TO EXPENSES

Provider CCN: 262010

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

Worksheet A-8

Date/Time Prepared:
1/30/2013 1:33 pm

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 RENT - VENTAS OTHER	0	33.32
33.33	0	33.33
33.34 MALPRACTICE TAIL LIABILITY	0	33.34
33.35 AGGREGATE CAP PYMT-NONALLOWABLE	0	33.35
33.36	0	33.36
33.37 PHYSICIAN BILLING COLLECTION FEES	0	33.37
33.38 MEDICARE VS BOOK BLDG	9	33.38
33.39 MEDICARE VS BOOK MOV EQUIP	9	33.39
33.40 ASSET ADD-ON BLDG	9	33.40
33.41 ASSET ADD-ON MOV EQUIP	9	33.41
33.42	0	33.42
33.43	0	33.43
33.44 NON ALLOWABLE LOBBYING FEES	0	33.44
33.45	0	33.45
33.46 BUSINESS INTERRUPTION INS PREMIUM	12	33.46
33.47	0	33.47
33.48	0	33.48
33.49	0	33.49
33.50	0	33.50
33.51	0	33.51
33.52 PATIENT PHONE - DEPREC EQUIP	9	33.52
33.53	0	33.53
33.54 OVERSTMT DUE TO DIFF GAAP VS AHA	9	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 PHYSICIAN FEE ADJUSTMENT	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 PHYSICIAN FEE ADJUSTMENT	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	0	33.79
33.80 PHYSICIAN FEE ADJUSTMENT	0	33.80
33.81	0	33.81
33.82	0	33.82
33.83	0	33.83
33.84	0	33.84
33.85	0	33.85
33.86	0	33.86
33.87	0	33.87
33.88	0	33.88
33.89 FRA TAX - ADJUST TO ACTUAL	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: 262010

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

Worksheet A-8-1

Date/Time Prepared:
1/30/2013 1:33 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	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: 262010

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

Worksheet A-8-1

Date/Time Prepared: 1/30/2013 1:33 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1,762,684	1,777,836	-15,152	0	1.00
2.00	205,677	205,677	0	0	2.00
3.00	194,476	194,476	0	0	3.00
4.00	0	0	0	0	4.00
4.01	1,096,618	1,159,564	-62,946	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.	3,337,553	-78,098		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: 262010

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

Worksheet A-8-2

Date/Time Prepared:
1/30/2013 1:33 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	30.00	DR. A	798,976	0	1.00
2.00	0.00	DR. B	0	0	2.00
3.00	74.00	DR. C	2,731	0	3.00
4.00	30.00	DR. D	18,633	0	4.00
5.00	30.00	DR. E	19,225	0	5.00
6.00	30.00	DR. F	7,395	0	6.00
7.00	30.00	DR. G	8,877	0	7.00
8.00	65.00	DR. H	7,767	7,767	8.00
9.00	30.00	DR. I	4,979	0	9.00
10.00	74.00	DR. J	2,720	0	10.00
11.00	16.00	DR. K	5,201	0	11.00
12.00	30.00	DR. L	2,320	0	12.00
13.00	65.00	DR. M	7,767	7,767	13.00
200.00			886,591	15,534	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 262010

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

Worksheet A-8-2

Date/Time Prepared:
1/30/2013 1:33 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	798,976	177,200	9,727	828,666	41,433	1.00
2.00	0	0	0	0	0	2.00
3.00	2,731	177,200	19	1,619	81	3.00
4.00	18,633	177,200	132	11,245	562	4.00
5.00	19,225	177,200	137	11,671	584	5.00
6.00	7,395	177,200	41	3,493	175	6.00
7.00	8,877	177,200	66	5,623	281	7.00
8.00	0	177,200	0	0	0	8.00
9.00	4,979	177,200	36	3,067	153	9.00
10.00	2,720	177,200	21	1,789	89	10.00
11.00	5,201	177,200	39	3,323	166	11.00
12.00	2,320	177,200	17	1,448	72	12.00
13.00	0	177,200	0	0	0	13.00
200.00	871,057		10,235	871,944	43,596	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 262010

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

Worksheet A-8-2

Date/Time Prepared:
1/30/2013 1:33 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	828,666	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	1,619	3.00
4.00	0	0	0	0	11,245	4.00
5.00	0	0	0	0	11,671	5.00
6.00	0	0	0	0	3,493	6.00
7.00	0	0	0	0	5,623	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	3,067	9.00
10.00	0	0	0	0	1,789	10.00
11.00	0	0	0	0	3,323	11.00
12.00	0	0	0	0	1,448	12.00
13.00	0	0	0	0	0	13.00
200.00	0	0	0	0	871,944	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 262010

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

Worksheet A-8-2

Date/Time Prepared:
1/30/2013 1:33 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	0	1.00
2.00	0	0	2.00
3.00	1,112	1,112	3.00
4.00	7,388	7,388	4.00
5.00	7,554	7,554	5.00
6.00	3,902	3,902	6.00
7.00	3,254	3,254	7.00
8.00	0	7,767	8.00
9.00	1,912	1,912	9.00
10.00	931	931	10.00
11.00	1,878	1,878	11.00
12.00	872	872	12.00
13.00	0	7,767	13.00
200.00	28,803	44,337	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 262010

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

Worksheet B
Part I
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,823,469	2,823,469			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	737,794		737,794		2.00
4.00 00400	EMPLOYEE BENEFITS	2,336,458	8,028	2,098	2,346,584	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,637,813	456,881	119,386	322,513	6,536,593
7.00 00700	OPERATION OF PLANT	710,279	147,285	38,487	29,654	925,705
8.00 00800	LAUNDRY & LINEN SERVICE	143,840	60,983	15,935	0	220,758
9.00 00900	HOUSEKEEPING	341,982	42,765	11,175	47,904	443,826
10.00 01000	DIETARY	543,447	95,977	25,079	42,936	707,439
11.00 01100	CAFETERIA	0	36,229	9,467	0	45,696
13.00 01300	NURSING ADMINISTRATION	1,408,977	91,397	23,883	289,669	1,813,926
14.00 01400	CENTRAL SERVICES & SUPPLY	132,868	171,781	44,888	23,250	372,787
15.00 01500	PHARMACY	1,237,859	172,295	45,022	0	1,455,176
16.00 01600	MEDICAL RECORDS & LIBRARY	475,071	64,173	16,769	85,288	641,301
17.00 01700	SOCIAL SERVICE	638,804	40,604	10,610	116,402	806,420
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,418,478	1,166,181	304,731	1,048,775	8,938,165
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	402,239	21,511	5,621	0	429,371
54.00 05400	RADIOLOGY-DIAGNOSTIC	456,565	41,839	10,933	15,249	524,586
60.00 06000	LABORATORY	626,349	51,153	13,367	14,746	705,615
65.00 06500	RESPIRATORY THERAPY	1,466,453	65,872	17,213	289,336	1,838,874
66.00 06600	PHYSICAL THERAPY	1,105,834	48,889	12,775	0	1,167,498
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	1,194,775	0	0	0	1,194,775
73.00 07300	DRUGS CHARGED TO PATIENTS	1,993,837	0	0	0	1,993,837
74.00 07400	RENAL DIALYSIS	629,651	39,626	10,355	0	679,632
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 09900	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	31,462,842	2,823,469	737,794	2,325,722	31,441,980
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	114,489	0	0	20,862	135,351
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	0	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					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	31,577,331	2,823,469	737,794	2,346,584	31,577,331

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 262010

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

Worksheet B
Part I
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	6,536,593					5.00
7.00	00700	241,644	1,167,349				7.00
8.00	00800	57,626	32,193	310,577			8.00
9.00	00900	115,855	22,576	0	582,257		9.00
10.00	01000	184,668	50,667	0	26,516	969,290	10.00
11.00	01100	11,928	19,126	0	10,009	164,255	11.00
13.00	01300	473,504	48,249	0	25,251	0	13.00
14.00	01400	97,312	90,684	0	47,459	0	14.00
15.00	01500	379,856	90,956	0	47,601	0	15.00
16.00	01600	167,404	33,878	0	17,729	0	16.00
17.00	01700	210,506	21,435	0	11,218	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,333,211	615,636	310,577	322,186	805,035	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	112,082	11,356	0	5,943	0	50.00
54.00	05400	136,937	22,087	0	11,559	0	54.00
60.00	06000	184,192	27,004	0	14,132	0	60.00
65.00	06500	480,016	34,774	0	18,199	0	65.00
66.00	06600	304,761	25,809	0	13,507	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	311,882	0	0	0	0	71.00
73.00	07300	520,467	0	0	0	0	73.00
74.00	07400	177,410	20,919	0	10,948	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		6,501,261	1,167,349	310,577	582,257	969,290	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	35,332	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		6,536,593	1,167,349	310,577	582,257	969,290	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 262010

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

Worksheet B
Part I
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	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	251,014					11.00
13.00	01300	25,706	2,386,636				13.00
14.00	01400	4,536	0	612,778			14.00
15.00	01500	0	0	10,693	1,984,282		15.00
16.00	01600	10,585	0	413	0	871,310	16.00
17.00	01700	12,097	0	211	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	158,775	2,386,636	14,289	0	242,559	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	10,215	50.00
54.00	05400	1,512	0	341	0	12,512	54.00
60.00	06000	1,512	0	20,128	0	59,663	60.00
65.00	06500	36,291	0	8,882	0	207,008	65.00
66.00	06600	0	0	3,100	0	39,878	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	554,721	0	69,824	71.00
73.00	07300	0	0	0	1,984,282	216,883	73.00
74.00	07400	0	0	0	0	12,768	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	09500	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		251,014	2,386,636	612,778	1,984,282	871,310	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		251,014	2,386,636	612,778	1,984,282	871,310	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 262010

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

Worksheet B
Part I
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	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	1,061,887			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,061,887	17,188,956	0	17,188,956
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	568,967	0	568,967
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	709,534	0	709,534
60.00	06000	LABORATORY	0	1,012,246	0	1,012,246
65.00	06500	RESPIRATORY THERAPY	0	2,624,044	0	2,624,044
66.00	06600	PHYSICAL THERAPY	0	1,554,553	0	1,554,553
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	2,131,202	0	2,131,202
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,715,469	0	4,715,469
74.00	07400	RENAL DIALYSIS	0	901,677	0	901,677
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
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,061,887	31,406,648	0	31,406,648
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	170,683	0	170,683
194.01	07951	IDLE SPACE	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)	0	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,061,887	31,577,331	0	31,577,331

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet B Part II Date/Time Prepared: 1/30/2013 1:33 pm
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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	8,028	2,098	10,126	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	194,895	456,881	119,386	771,162	5.00
7.00 00700	OPERATION OF PLANT	0	147,285	38,487	185,772	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	60,983	15,935	76,918	8.00
9.00 00900	HOUSEKEEPING	0	42,765	11,175	53,940	9.00
10.00 01000	DIETARY	0	95,977	25,079	121,056	10.00
11.00 01100	CAFETERIA	0	36,229	9,467	45,696	11.00
13.00 01300	NURSING ADMINISTRATION	0	91,397	23,883	115,280	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	171,781	44,888	216,669	14.00
15.00 01500	PHARMACY	0	172,295	45,022	217,317	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	64,173	16,769	80,942	16.00
17.00 01700	SOCIAL SERVICE	0	40,604	10,610	51,214	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,166,181	304,731	1,470,912	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	21,511	5,621	27,132	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	41,839	10,933	52,772	54.00
60.00 06000	LABORATORY	0	51,153	13,367	64,520	60.00
65.00 06500	RESPIRATORY THERAPY	0	65,872	17,213	83,085	65.00
66.00 06600	PHYSICAL THERAPY	0	48,889	12,775	61,664	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	39,626	10,355	49,981	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)	194,895	2,823,469	737,794	3,756,158	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	90 194.00
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				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	194,895	2,823,469	737,794	3,756,158	10,126 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet B Part II Date/Time Prepared: 1/30/2013 1:33 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	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	772,553				5.00	
7.00	00700	OPERATION OF PLANT	28,560	214,460			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	6,811	5,914	89,643		8.00	
9.00	00900	HOUSEKEEPING	13,693	4,148	0	71,988	9.00	
10.00	01000	DIETARY	21,826	9,308	0	3,278	155,653	10.00
11.00	01100	CAFETERIA	1,410	3,514	0	1,238	26,377	11.00
13.00	01300	NURSING ADMINISTRATION	55,963	8,864	0	3,122	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,501	16,660	0	5,868	0	14.00
15.00	01500	PHARMACY	44,895	16,710	0	5,885	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,785	6,224	0	2,192	0	16.00
17.00	01700	SOCIAL SERVICE	24,880	3,938	0	1,387	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	275,755	113,102	89,643	39,833	129,276	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	13,247	2,086	0	735	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,185	4,058	0	1,429	0	54.00
60.00	06000	LABORATORY	21,770	4,961	0	1,747	0	60.00
65.00	06500	RESPIRATORY THERAPY	56,733	6,389	0	2,250	0	65.00
66.00	06600	PHYSICAL THERAPY	36,020	4,741	0	1,670	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	36,861	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,514	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	20,968	3,843	0	1,354	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)	768,377	214,460	89,643	71,988	155,653	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	4,176	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	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	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	772,553	214,460	89,643	71,988	155,653	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 262010

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

Worksheet B
Part II
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	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	78,235					11.00
13.00	01300	8,012	192,491				13.00
14.00	01400	1,414	0	252,212			14.00
15.00	01500	0	0	4,401	289,208		15.00
16.00	01600	3,299	0	170	0	112,980	16.00
17.00	01700	3,770	0	87	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	49,487	192,491	5,881	0	31,457	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	1,324	50.00
54.00	05400	471	0	140	0	1,622	54.00
60.00	06000	471	0	8,284	0	7,736	60.00
65.00	06500	11,311	0	3,656	0	26,841	65.00
66.00	06600	0	0	1,276	0	5,171	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	228,317	0	9,053	71.00
73.00	07300	0	0	0	289,208	28,121	73.00
74.00	07400	0	0	0	0	1,655	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		78,235	192,491	252,212	289,208	112,980	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		78,235	192,491	252,212	289,208	112,980	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 262010

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

Worksheet B
Part II
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	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	85,778				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	85,778	2,488,142	0	2,488,142	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	44,524	0	44,524	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	76,743	0	76,743	54.00
60.00	06000	LABORATORY	0	109,553	0	109,553	60.00
65.00	06500	RESPIRATORY THERAPY	0	191,513	0	191,513	65.00
66.00	06600	PHYSICAL THERAPY	0	110,542	0	110,542	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	274,231	0	274,231	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	378,843	0	378,843	73.00
74.00	07400	RENAL DIALYSIS	0	77,801	0	77,801	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)	85,778	3,751,892	0	3,751,892	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	4,266	0	4,266	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	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	85,778	3,756,158	0	3,756,158	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 262010

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

Worksheet B-1
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	54,865				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		54,865			2.00
4.00 00400	EMPLOYEE BENEFITS	156	156	11,322,726		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,878	8,878	1,556,190	-6,536,593	25,040,738
7.00 00700	OPERATION OF PLANT	2,862	2,862	143,086	0	925,705
8.00 00800	LAUNDRY & LINEN SERVICE	1,185	1,185	0	0	220,758
9.00 00900	HOUSEKEEPING	831	831	231,145	0	443,826
10.00 01000	DIETARY	1,865	1,865	207,176	0	707,439
11.00 01100	CAFETERIA	704	704	0	0	45,696
13.00 01300	NURSING ADMINISTRATION	1,776	1,776	1,397,712	0	1,813,926
14.00 01400	CENTRAL SERVICES & SUPPLY	3,338	3,338	112,188	0	372,787
15.00 01500	PHARMACY	3,348	3,348	0	0	1,455,176
16.00 01600	MEDICAL RECORDS & LIBRARY	1,247	1,247	411,532	0	641,301
17.00 01700	SOCIAL SERVICE	789	789	561,663	0	806,420
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	22,661	22,661	5,060,532	0	8,938,165
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	418	418	0	0	429,371
54.00 05400	RADIOLOGY-DIAGNOSTIC	813	813	73,581	0	524,586
60.00 06000	LABORATORY	994	994	71,152	0	705,615
65.00 06500	RESPIRATORY THERAPY	1,280	1,280	1,396,105	0	1,838,874
66.00 06600	PHYSICAL THERAPY	950	950	0	0	1,167,498
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	1,194,775
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,993,837
74.00 07400	RENAL DIALYSIS	770	770	0	0	679,632
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 09950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	54,865	54,865	11,222,062	-6,536,593	24,905,387
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	100,664	0	135,351
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	0	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)	2,823,469	737,794	2,346,584		6,536,593
203.00	Unit cost multiplier (Wkst. B, Part I)	51.462116	13.447444	0.207245		0.261038
204.00	Cost to be allocated (per Wkst. B, Part II)			10,126		772,553
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000894		0.030852

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 262010

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

Worksheet B-1

Date/Time Prepared:
1/30/2013 1:33 pm

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	42,969				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,185	19,715			8.00
9.00	00900	HOUSEKEEPING	831	0	40,953		9.00
10.00	01000	DIETARY	1,865	0	1,865	21,604	10.00
11.00	01100	CAFETERIA	704	0	704	3,661	166
13.00	01300	NURSING ADMINISTRATION	1,776	0	1,776	0	17
14.00	01400	CENTRAL SERVICES & SUPPLY	3,338	0	3,338	0	3
15.00	01500	PHARMACY	3,348	0	3,348	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,247	0	1,247	0	7
17.00	01700	SOCIAL SERVICE	789	0	789	0	8
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,661	19,715	22,661	17,943	105
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	418	0	418	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	813	0	813	0	1
60.00	06000	LABORATORY	994	0	994	0	1
65.00	06500	RESPIRATORY THERAPY	1,280	0	1,280	0	24
66.00	06600	PHYSICAL THERAPY	950	0	950	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	770	0	770	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)	42,969	19,715	40,953	21,604	166
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	0	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)	1,167,349	310,577	582,257	969,290	251,014
203.00		Unit cost multiplier (Wkst. B, Part I)	27.167237	15.753335	14.217689	44.866228	1,512.132530
204.00		Cost to be allocated (per Wkst. B, Part II)	214,460	89,643	71,988	155,653	78,235
205.00		Unit cost multiplier (Wkst. B, Part II)	4.991040	4.546944	1.757820	7.204823	471.295181

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 262010

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

Worksheet B-1
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
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	105					13.00
14.00	01400	0	1,319,820				14.00
15.00	01500	0	23,030	1,993,837			15.00
16.00	01600	0	890	0	115,627,833		16.00
17.00	01700	0	454	0	0	19,715	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	105	30,777	0	32,183,894	19,715	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	1,355,615	0	50.00
54.00	05400	0	735	0	1,660,569	0	54.00
60.00	06000	0	43,352	0	7,918,061	0	60.00
65.00	06500	0	19,130	0	27,472,835	0	65.00
66.00	06600	0	6,677	0	5,292,408	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	1,194,775	0	9,266,622	0	71.00
73.00	07300	0	0	1,993,837	28,783,360	0	73.00
74.00	07400	0	0	0	1,694,469	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		105	1,319,820	1,993,837	115,627,833	19,715	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		2,386,636	612,778	1,984,282	871,310	1,061,887	202.00
203.00		22,729.866667	0.464289	0.995208	0.007535	53.861882	203.00
204.00		192,491	252,212	289,208	112,980	85,778	204.00
205.00		1,833.247619	0.191096	0.145051	0.000977	4.350900	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 262010

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

Worksheet C
Part I
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE	Total Costs	
					Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	17,188,956		17,188,956	24,882	17,213,838	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	568,967		568,967	0	568,967	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	709,534		709,534	0	709,534	54.00
60.00	06000 LABORATORY	1,012,246		1,012,246	0	1,012,246	60.00
65.00	06500 RESPIRATORY THERAPY	2,624,044	0	2,624,044	0	2,624,044	65.00
66.00	06600 PHYSICAL THERAPY	1,554,553	0	1,554,553	0	1,554,553	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	2,131,202		2,131,202	0	2,131,202	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,715,469		4,715,469	0	4,715,469	73.00
74.00	07400 RENAL DIALYSIS	901,677		901,677	2,043	903,720	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)	31,406,648	0	31,406,648	26,925	31,433,573	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	31,406,648	0	31,406,648	26,925	31,433,573	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 262010

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

Worksheet C
Part I
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	32,183,894		32,183,894		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	1,355,615	0	1,355,615	0.419711	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,660,569	0	1,660,569	0.427284	54.00
60.00	06000	LABORATORY	7,918,061	0	7,918,061	0.127840	60.00
65.00	06500	RESPIRATORY THERAPY	27,472,835	0	27,472,835	0.095514	65.00
66.00	06600	PHYSICAL THERAPY	5,292,408	0	5,292,408	0.293733	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	9,266,622	0	9,266,622	0.229987	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,783,360	0	28,783,360	0.163826	73.00
74.00	07400	RENAL DIALYSIS	1,694,469	0	1,694,469	0.532130	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)	115,627,833	0	115,627,833		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	115,627,833	0	115,627,833		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 262010

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

Worksheet C
Part I
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
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	0.419711			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.427284			54.00
60.00	06000 LABORATORY	0.127840			60.00
65.00	06500 RESPIRATORY THERAPY	0.095514			65.00
66.00	06600 PHYSICAL THERAPY	0.293733			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	0.229987			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.163826			73.00
74.00	07400 RENAL DIALYSIS	0.533335			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

Provider CCN: 262010

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

Worksheet C
Part I
Date/Time Prepared:
1/30/2013 1:33 pm

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	17,188,956		17,188,956	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	568,967		568,967	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	709,534		709,534	0	0	54.00
60.00	06000 LABORATORY	1,012,246		1,012,246	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	2,624,044	0	2,624,044	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,554,553	0	1,554,553	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	2,131,202		2,131,202	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,715,469		4,715,469	0	0	73.00
74.00	07400 RENAL DIALYSIS	901,677		901,677	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)	31,406,648	0	31,406,648	0	0	200.00
201.00	Less Observation Beds	0		0			201.00
202.00	Total (see instructions)	31,406,648	0	31,406,648	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 262010

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

Worksheet C
Part I
Date/Time Prepared:
1/30/2013 1:33 pm

		Title XIX			Hospital	Cost		
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,183,894		32,183,894			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	1,355,615	0	1,355,615	0.419711	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,660,569	0	1,660,569	0.427284	0.000000	54.00
60.00	06000	LABORATORY	7,918,061	0	7,918,061	0.127840	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	27,472,835	0	27,472,835	0.095514	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,292,408	0	5,292,408	0.293733	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,266,622	0	9,266,622	0.229987	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,783,360	0	28,783,360	0.163826	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,694,469	0	1,694,469	0.532130	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)	115,627,833	0	115,627,833			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	115,627,833	0	115,627,833			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 262010

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

Worksheet C
Part I
Date/Time Prepared:
1/30/2013 1:33 pm

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 262010		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part I Date/Time Prepared: 1/30/2013 1:33 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,488,142	0	2,488,142	19,715	126.21	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)	2,488,142		2,488,142	19,715		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part I Date/Time Prepared: 1/30/2013 1:33 pm
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	10,140	1,279,769	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)	10,140	1,279,769	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part II Date/Time Prepared: 1/30/2013 1:33 pm
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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	44,524	1,355,615	0.032844	1,051,905	34,549	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	76,743	1,660,569	0.046215	890,899	41,173	54.00
60.00	06000 LABORATORY	109,553	7,918,061	0.013836	4,465,036	61,778	60.00
65.00	06500 RESPIRATORY THERAPY	191,513	27,472,835	0.006971	14,182,630	98,867	65.00
66.00	06600 PHYSICAL THERAPY	110,542	5,292,408	0.020887	2,839,514	59,309	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	274,231	9,266,622	0.029593	4,781,982	141,513	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	378,843	28,783,360	0.013162	14,950,836	196,783	73.00
74.00	07400 RENAL DIALYSIS	77,801	1,694,469	0.045915	857,252	39,361	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)	1,263,750	83,443,939		44,020,054	673,333	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 262010		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part III Date/Time Prepared: 1/30/2013 1:33 pm	
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: 262010		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part III Date/Time Prepared: 1/30/2013 1:33 pm	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PPS	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,715	0.00	10,140	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)	19,715		10,140	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 262010

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

Worksheet D
Part IV
Date/Time Prepared:
1/30/2013 1:33 pm

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part IV Date/Time Prepared: 1/30/2013 1:33 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	1,355,615	0.000000	0.000000	1,051,905	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,660,569	0.000000	0.000000	890,899	54.00
60.00	06000 LABORATORY	0	7,918,061	0.000000	0.000000	4,465,036	60.00
65.00	06500 RESPIRATORY THERAPY	0	27,472,835	0.000000	0.000000	14,182,630	65.00
66.00	06600 PHYSICAL THERAPY	0	5,292,408	0.000000	0.000000	2,839,514	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,266,622	0.000000	0.000000	4,781,982	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	28,783,360	0.000000	0.000000	14,950,836	73.00
74.00	07400 RENAL DIALYSIS	0	1,694,469	0.000000	0.000000	857,252	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	83,443,939			44,020,054	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 262010

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

Worksheet D
Part IV
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part V Date/Time Prepared: 1/30/2013 1:33 pm
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Hospital	PPS	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)			Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.419711	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.427284	0	36,412	0	54.00
60.00	06000	LABORATORY	0.127840	0	1,241	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.095514	0	152,938	0	65.00
66.00	06600	PHYSICAL THERAPY	0.293733	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	0.229987	0	410	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163826	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.532130	0	157,164	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	98.00
200.00		Subtotal (see instructions)		0	348,165	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	348,165	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part V Date/Time Prepared: 1/30/2013 1:33 pm
	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	0	15,558	0	54.00
60.00	06000	LABORATORY	0	159	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,608	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	94	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	83,632	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)	0	114,051	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	114,051	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 1/30/2013 1:33 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		19,715	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,715	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)		19,715	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)		10,140	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)		17,213,838	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)		17,213,838	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		32,183,894	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		32,183,894	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.534859	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)		1,632.46	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)		17,213,838	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)		873.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,853,538	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)		8,853,538	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1 Date/Time Prepared: 1/30/2013 1:33 pm
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					7,588,004
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					16,441,542
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,279,769
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					673,333
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,953,102
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					14,488,440
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 262010		Period: From 09/01/2011 To 08/31/2012		Worksheet D-1 Date/Time Prepared: 1/30/2013 1:33 pm	
Title XVIII		Hospital		PPS			
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,488,142	17,213,838	0.144543	0	0	90.00
91.00	Nursing School cost	0	17,213,838	0.000000	0	0	91.00
92.00	Allied health cost	0	17,213,838	0.000000	0	0	92.00
93.00	All other Medical Education	0	17,213,838	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 1/30/2013 1:33 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		19,715	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,715	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)		19,715	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)		62	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)		17,188,956	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)		17,188,956	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		32,183,894	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		32,183,894	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.534086	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)		1,632.46	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)		17,188,956	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)		871.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		54,056	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)		54,056	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1 Date/Time Prepared: 1/30/2013 1:33 pm			
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	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								
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						47,805	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						101,861	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: 262010

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

Worksheet D-1
Date/Time Prepared:
1/30/2013 1:33 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet D-3 Date/Time Prepared: 1/30/2013 1:33 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		16,613,774		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.419711	1,051,905	441,496	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.427284	890,899	380,667	54.00
60.00	06000 LABORATORY	0.127840	4,465,036	570,810	60.00
65.00	06500 RESPIRATORY THERAPY	0.095514	14,182,630	1,354,640	65.00
66.00	06600 PHYSICAL THERAPY	0.293733	2,839,514	834,059	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	0.229987	4,781,982	1,099,794	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.163826	14,950,836	2,449,336	73.00
74.00	07400 RENAL DIALYSIS	0.533335	857,252	457,202	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)		44,020,054	7,588,004	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)		44,020,054		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet D-3 Date/Time Prepared: 1/30/2013 1:33 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		113,918	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.419711	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.427284	2,191	54.00
60.00	06000	LABORATORY	0.127840	12,493	60.00
65.00	06500	RESPIRATORY THERAPY	0.095514	193,932	65.00
66.00	06600	PHYSICAL THERAPY	0.293733	18,416	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.229987	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163826	38,143	73.00
74.00	07400	RENAL DIALYSIS	0.532130	28,359	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		293,534	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)		293,534	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet E Part B Date/Time Prepared: 1/30/2013 1:33 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		114,051	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		114,051	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		348,165	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)		348,165	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)		348,165	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		234,114	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)		114,051	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		69,633	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		44,418	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)		44,418	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		44,418	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)		44,418	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)		44,418	40.00
41.00	Interim payments		17,487	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)		26,931	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: 262010

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

Worksheet E-1
Part I
Date/Time Prepared:
1/30/2013 1:33 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		14,624,233		17,487	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	12/01/2011	351,200		0	3.01	
3.02		06/05/2012	259,500		0	3.02	
3.03		06/18/2012	58,600		0	3.03	
3.04		11/29/2012	695,800		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)		1,365,100		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		15,989,333		17,487	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		84,189		26,931	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		16,073,522		44,418	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: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet E-3 Part IV Date/Time Prepared: 1/30/2013 1:33 pm
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		15,375,254	1.00
2.00	Outlier Payments		1,645,433	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		17,020,687	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)		17,020,687	7.00
8.00	Primary payer payments		22,911	8.00
9.00	Subtotal (line 7 less line 8)		16,997,776	9.00
10.00	Deductibles		27,528	10.00
11.00	Subtotal (line 9 minus line 10)		16,970,248	11.00
12.00	Coinsurance		1,459,250	12.00
13.00	Subtotal (line 11 minus line 12)		15,510,998	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		803,606	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		562,524	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		660,607	16.00
17.00	Subtotal (sum of lines 13 and 15)		16,073,522	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)		16,073,522	22.00
23.00	Interim payments		15,989,333	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)		84,189	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: 262010	Period: From 09/01/2011 To 08/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 1/30/2013 1:33 pm	
		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		101,861		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)		101,861	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)		101,861	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		113,918		8.00
9.00	Ancillary service charges		293,534	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)		407,452	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)		407,452	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		305,591	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)		101,861	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)		101,861	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)		101,861	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)		101,861	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)		101,861	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)		101,861	0	40.00
41.00	Interim payments		37,449		41.00
42.00	Balance due provider/program (line 40 minus 41)		64,412		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0		43.00

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

Provider CCN: 262010

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

Worksheet G

Date/Time Prepared:
1/30/2013 1:33 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	287,057	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	10,042,726	0	0	0	4.00
5.00	Other receivable	1,955	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,066,423	0	0	0	6.00
7.00	Inventory	250,670	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)	8,515,985	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,201,998	0	0	0	17.00
18.00	Accumulated depreciation	-1,032,993	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	4,782,205	0	0	0	23.00
24.00	Accumulated depreciation	-3,545,460	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)	1,405,750	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	86,323	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	86,323	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,008,058	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,196,355	0	0	0	37.00
38.00	Salaries, wages, and fees payable	786,574	0	0	0	38.00
39.00	Payroll taxes payable	29,952	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	497,079	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,509,960	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	-21,781,294	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-21,781,294	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-19,271,334	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	29,279,392				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)	29,279,392	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,008,058	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 262010

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

Worksheet G-1

Date/Time Prepared:
1/30/2013 1:33 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		29,215,185		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		64,213			2.00
3.00	Total (sum of line 1 and line 2)		29,279,398		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)		29,279,398		0	11.00
12.00	Deductions (debit adjustments)	0		0		12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	6		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)		6		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		29,279,392		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 262010

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

Worksheet G-1

Date/Time Prepared:
1/30/2013 1:33 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 262010

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
1/30/2013 1:33 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	32,183,894		32,183,894	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)	32,183,894		32,183,894	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)	32,183,894		32,183,894	17.00
18.00	Ancillary services	83,443,939	0	83,443,939	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)	115,627,833	0	115,627,833	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,064,475		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)		33,064,475		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 262010

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

Worksheet G-3

Date/Time Prepared:
1/30/2013 1:33 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	115,627,833	1.00
2.00	Less contractual allowances and discounts on patients' accounts	82,640,878	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,986,955	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,064,475	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-77,520	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	2,064	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	8,671	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	60	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	130,938	24.00
25.00	Total other income (sum of lines 6-24)	141,733	25.00
26.00	Total (line 5 plus line 25)	64,213	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)	64,213	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

Provider CCN: 262010

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

Worksheet I-5

Date/Time Prepared:
1/30/2013 1:33 pm

		1.00	
1.00	Total expenses related to care of program beneficiaries (see instructions)	0	1.00
2.00	Total payment (from Worksheet I-4, column 6, line 11)	0	2.00
3.00	Deductibles billed to Medicare (Part B) patients	0	3.00
4.00	Coinsurance billed to Medicare (Part B) patients	0	4.00
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	5.00
6.00			6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (sum of lines 3 and 4 less line 5)	0	8.00
9.00	Program payment (line 2 less line 3, times 80 percent)	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (Line 1 minus the sum of lines 8 and 9. If negative, enter zero and do not complete line 11.)	0	10.00
11.00	Reimbursable bad debts (lesser of line 10 or line 5) (transfer to Worksheet E, Part B, line 33)	0	11.00