

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: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet S Parts I-III Date/Time Prepared: 2/15/2012 9:56 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 2/15/2012	Time: 9:56 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 INTEGRA SPECIALTY HOSPITAL for the cost reporting period beginning 09/01/2010 and ending 08/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

	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	106,540	0	0	23,415 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	106,540	0	0	23,415 200.00

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.

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: 152025 Period: From 09/01/2010 To 08/31/2011 Worksheet S Parts I-III Date/Time Prepared: 2/15/2012 9:56 am

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 2/15/2012 Time: 9:56 am
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only 5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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Encryption Information
 ECR: Date: 2/15/2012 Time: 9:56 am
 i xZKaZurfdWVuuVOSMy9cShmf22qVO
 M5j 2EOzN00THzsu4BNI bt0tuFI 2ZPN
 : 8nv0hBj PH0m3NrI
 PI: Date: 2/15/2012 Time: 9:56 am
 7i zfTH3Yoy78VDmcYsq0TMZ. ZN. U00
 aFLOt0aUCdh4soj j XoGhzT9soLpu00
 UVEMKNc6V30vPTUJ

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

 Title

 Date

	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	106,540	0	0	23,415	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	106,540	0	0	23,415	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: 152025		Period: From 09/01/2010 To 08/31/2011		Worksheet S-2 Part I Date/Time Prepared: 2/13/2012 2:49 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 2401 W. UNIVERSITY AVE, 8TH FLOOR N			PO Box:				1.00		
2.00	City: MUNCI E			State: IN		Zip Code: 47303		County: DELAWARE		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		INTEGRA SPECIALTY HOSPITAL	152025	34620	2	02/16/2005	N	P	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF						N	N	N	
8.00	Swing Beds - NF						N		N	
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA						N	N	N	
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC						N	N	N	
16.00	Hospital-Based Health Clinic - FQHC						N	N	N	
17.00	Hospital-Based (CMHC) 1						N	N	N	
17.10	Hospital-Based (CORF) 1						N	N	N	
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2010	08/31/2011		20.00
21.00	Type of Control (see instructions)						2		21.00	
Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N	
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						2		N	
				In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.			0	0	0	0	0	0	
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.			0	0	0	0	0	0	
							1.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.								1	26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.								1	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								0	35.00
							Beginni ng:	Endi ng:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.									36.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet S-2 Part I Date/Time Prepared: 2/13/2012 2:49 pm		
		Beginning:	Ending:			
		1.00	2.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N	N		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.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
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 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

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		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1 the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000		65.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
				1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010									
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000		67.00	
						1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					N		0	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		0	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 or "N" for no.						Y		80.00

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				1.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.		N	N	86.00
			V	XIX	
			1.00	2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	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)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	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
				1.00	2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.			1	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 152025		Period: From 09/01/2010 To 08/31/2011		Worksheet S-2 Part I Date/Time Prepared: 2/13/2012 2:49 pm	
			1.00				2.00	
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			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: TENDER LOVING CARE MANAGEMENT, INC.	Contractor's Name: ADMINSTAR FEDERAL		Contractor's Number:				141.00
142.00	Street: 1800 N. WABASH AVE., SUITE 300	PO Box:						142.00
143.00	City: MARION	State: IN		Zip Code: 46952				143.00
							1.00	
144.00	Are provider based physicians' costs included in Worksheet A?				Y			144.00
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.				Y			145.00
							1.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N			146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N			147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N			148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N			149.00
							Part A	Part B
							1.00	2.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital				N		N	155.00
156.00	Subprovider - IPF				N		N	156.00
157.00	Subprovider - IRF				N		N	157.00
158.00	Subprovider - Other				N		N	158.00
159.00	SNF				N		N	159.00
160.00	HHA				N		N	160.00
161.00	CMHC						N	161.00
							1.00	
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
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00
								169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet S-2 Part II Date/Time Prepared: 2/13/2012 2:49 pm
			Y/N 1.00	Date 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 1.00	Date 2.00
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 1.00	Type 2.00
				Date 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.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
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
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
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N
		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	12/02/2011	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:			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet S-2 Part II Date/Time Prepared: 2/13/2012 2:49 pm
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		Part A			
		Description	Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00 N	2.00	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		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.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet S-2
Part II
Date/Time Prepared:
2/13/2012 2:49 pm

		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)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	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:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet S-3
Part I
Date/Time Prepared:
2/13/2012 2:49 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	32	11,680	0.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		32	11,680	0.00		7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		32	11,680	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	0	0			21.00
22.00 HOME HEALTH AGENCY	101.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
25.00 CMHC - CMHC	99.00					25.00
25.10 CMHC - CORF	99.10					25.10
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00 Total (sum of lines 14-26)		32				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: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet S-3
Part I
Date/Time Prepared:
2/13/2012 2:49 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	5,277	29	6,771		1.00
2.00 HMO		0	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	5,277	29	6,771		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	5,277	29	6,771		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		19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE				0		21.00
22.00 HOME HEALTH AGENCY	0	0	0	0		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		0	0	0		24.00
25.00 CMHC - CMHC	0	0	0	0		25.00
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	0		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet S-3
Part I
Date/Time Prepared:
2/13/2012 2:49 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	216	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	54.57	0.00	0	216	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00	0.00	0.00			21.00
22.00 HOME HEALTH AGENCY	0.00	0.00	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	0.00	0.00			24.00
25.00 CMHC - CMHC	0.00	0.00	0.00			25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	54.57	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: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet S-3
Part I
Date/Time Prepared:
2/13/2012 2:49 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1	274		1.00
2.00 HMO				2.00
3.00 HMO IPF				3.00
4.00 HMO IRF				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	1	274		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE		0		21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet S-10 Date/Time Prepared: 2/13/2012 2:49 pm
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.391012	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		13,875	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		45,997	6.00
7.00	Medicaid cost (line 1 times line 6)		17,985	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		4,110	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		4,110	19.00
			1.00	
			2.00	
			3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,335	0	1,335
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	522	0	522
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	522	0	522
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		120,000	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		131,592	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		-11,592	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		-4,533	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		-4,011	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		99	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet A	Date/Time Prepared: 2/13/2012 2:49 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		0	0	0	0	1.00
2.00		488,995	488,995	0	488,995	2.00
3.00		0	0	0	0	3.00
4.00	0	512,040	512,040	0	512,040	4.00
5.00	569,353	137,050	706,403	0	706,403	5.00
6.00	0	0	0	0	0	6.00
7.00	0	42,162	42,162	0	42,162	7.00
8.00	430	47,240	47,670	0	47,670	8.00
9.00	0	114,680	114,680	0	114,680	9.00
10.00	0	215,472	215,472	0	215,472	10.00
11.00	0	0	0	0	0	11.00
12.00	0	0	0	0	0	12.00
13.00	40,199	0	40,199	0	40,199	13.00
14.00	0	0	0	0	0	14.00
15.00	0	0	0	0	0	15.00
16.00	161,746	22,647	184,393	0	184,393	16.00
17.00	0	0	0	0	0	17.00
18.00	0	0	0	0	0	18.00
19.00	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	2,285,395	949,116	3,234,511	-373,235	2,861,276	30.00
46.00	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	0	0	0	0	0	50.00
51.00	0	0	0	0	0	51.00
52.00	0	0	0	0	0	52.00
53.00	0	0	0	0	0	53.00
54.00	0	0	0	328,691	328,691	54.00
55.00	0	0	0	0	0	55.00
56.00	0	0	0	0	0	56.00
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	0	187,493	187,493	5,643	193,136	60.00
60.01	0	0	0	0	0	60.01
61.00	0	0	0	0	0	61.00
62.00	0	0	0	0	0	62.00
63.00	0	0	0	0	0	63.00
64.00	0	0	0	0	0	64.00
65.00	0	1,085,308	1,085,308	0	1,085,308	65.00
66.00	0	48,574	48,574	0	48,574	66.00
67.00	0	41,350	41,350	0	41,350	67.00
68.00	0	23,992	23,992	0	23,992	68.00
69.00	0	0	0	0	0	69.00
70.00	0	0	0	0	0	70.00
71.00	0	397,847	397,847	0	397,847	71.00
72.00	0	0	0	0	0	72.00
73.00	0	1,540,266	1,540,266	0	1,540,266	73.00
74.00	0	132,980	132,980	8,704	141,684	74.00
75.00	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	0	0	0	0	0	88.00
89.00	0	0	0	0	0	89.00
90.00	0	0	0	0	0	90.00
91.00	0	504,654	504,654	30,197	534,851	91.00
92.00	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.00	0	0	0	0	0	99.00
99.10	0	0	0	0	0	99.10
100.00	0	0	0	0	0	100.00
101.00	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	0	0	0	0	0	116.00
118.00	3,057,123	6,491,866	9,548,989	0	9,548,989	118.00
NONREIMBURSABLE COST CENTERS						
190.00	0	0	0	0	0	190.00
191.00	0	0	0	0	0	191.00
192.00	0	0	0	0	0	192.00
193.00	0	0	0	0	0	193.00
200.00	3,057,123	6,491,866	9,548,989	0	9,548,989	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES	Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet A Date/Time Prepared: 2/13/2012 2:49 pm
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Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
GENERAL SERVICE COST CENTERS		6.00	7.00	
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,581	490,576	2.00
3.00	OTHER CAP REL COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	0	512,040	4.00
5.00	ADMINISTRATIVE & GENERAL	5,181	711,584	5.00
6.00	MAINTENANCE & REPAIRS	0	0	6.00
7.00	OPERATION OF PLANT	0	42,162	7.00
8.00	LAUNDRY & LINEN SERVICE	0	47,670	8.00
9.00	HOUSEKEEPING	0	114,680	9.00
10.00	DIETARY	0	215,472	10.00
11.00	CAFETERIA	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	NURSING ADMINISTRATION	0	40,199	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	PHARMACY	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	184,393	16.00
17.00	SOCIAL SERVICE	0	0	17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-479,553	2,381,723	30.00
46.00	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0	50.00
51.00	RECOVERY ROOM	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	328,691	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	RADIOISOTOPE	0	0	56.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	193,136	60.00
60.01	BLOOD LABORATORY	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	0	1,085,308	65.00
66.00	PHYSICAL THERAPY	0	48,574	66.00
67.00	OCCUPATIONAL THERAPY	0	41,350	67.00
68.00	SPEECH PATHOLOGY	0	23,992	68.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	397,847	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,540,266	73.00
74.00	RENAL DIALYSIS	0	141,684	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	CLINIC	0	0	90.00
91.00	EMERGENCY	0	534,851	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
99.00	CMHC	0	0	99.00
99.10	CORF	0	0	99.10
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
116.00	HOSPICE	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-472,791	9,076,198	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	RESEARCH	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	NONPAID WORKERS	0	0	193.00
200.00	TOTAL (SUM OF LINES 118-199)	-472,791	9,076,198	200.00

RECLASSIFICATIONS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet A-6

Date/Time Prepared:
2/13/2012 2:49 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - TRANSPORTATION RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	26,112	1.00
2.00	RENAL DIALYSIS	74.00	0	8,704	2.00
3.00	EMERGENCY	91.00	0	8,704	3.00
	TOTALS		0	43,520	
B - PURCHASED SERVICES					
1.00	EMERGENCY	91.00	0	21,493	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	302,579	2.00
3.00	LABORATORY	60.00	0	5,643	3.00
	TOTALS		0	329,715	
500.00	Grand Total: Increases		0	373,235	500.00

RECLASSIFICATIONS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet A-6

Date/Time Prepared:
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Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - TRANSPORTATION RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	0	43,520	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	43,520			
B - PURCHASED SERVICES							
1.00	ADULTS & PEDIATRICS	30.00	0	329,715	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	329,715			
500.00	Grand Total: Decreases		0	373,235			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/13/2012 2:49 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	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	136,948	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	52,137	6,064	0	6,064	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	189,085	6,064	0	6,064	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	189,085	6,064	0	6,064	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	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	488,995	0	0	0	2.00
3.00	Total (sum of lines 1-2)	488,995	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	0	0	0	1.000000	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
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		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	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	136,948	0		4.00	
5.00	Fixed Equipment	0	0		5.00	
6.00	Movable Equipment	58,201	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	195,149	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	195,149	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	0		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	488,995		2.00	
3.00	Total (sum of lines 1-2)	0	488,995		3.00	
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	490,576	2.00
3.00	Total (sum of lines 1-2)	0	0	0	490,576	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	490,576	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	490,576	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet A-8

Date/Time Prepared:
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		Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
		Basis/Code (2)	Amount	Cost Center	Line #
		1.00	2.00	3.00	4.00
1.00	Investment income - buildings and fixtures (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.00
2.00	Investment income - movable equipment (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00
3.00	Investment income - other (chapter 2)		0		0.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00
8.00	Television and radio service (chapter 21)		0		0.00
9.00	Parking lot (chapter 21)		0		0.00
10.00	Provider-based physician adjustment	A-8-2	-479,553		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00
12.00	Related organization transactions (chapter 10)	A-8-1	50,708		12.00
13.00	Laundry and linen service		0		0.00
14.00	Cafeteria-employees and guests		0		0.00
15.00	Rental of quarters to employee and others		0		0.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00
17.00	Sale of drugs to other than patients		0		0.00
18.00	Sale of medical records and abstracts		0		0.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00
20.00	Vending machines	B	-280	ADMINISTRATIVE & GENERAL	5.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00
26.00	Depreciation - buildings and fixtures			OCAP REL COSTS-BLDG & FIXT	1.00
27.00	Depreciation - movable equipment			OCAP REL COSTS-MVBLE EQUIP	2.00
28.00	Non-physician Anesthetist			ONONPHYSICIAN ANESTHETISTS	19.00
29.00	Physicians' assistant			0	0.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00
33.00	MISCELLANEOUS INCOME	B	-26,907	ADMINISTRATIVE & GENERAL	5.00
33.01	ADVERTISING	A	-4,491	ADMINISTRATIVE & GENERAL	5.00
33.02	PUBLIC RELATIONS	A	-12,268	ADMINISTRATIVE & GENERAL	5.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-472,791		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet A-8

Date/Time Prepared:
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		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	0	1.00
2.00	Investment income - movable equipment (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - buildings and fixtures	0	26.00
27.00	Depreciation - movable equipment	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	MISCELLANEOUS INCOME	0	33.00
33.01	ADVERTISING	0	33.01
33.02	PUBLIC RELATIONS	0	33.02
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: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet A-8-1 Date/Time Prepared: 2/13/2012 2:49 pm
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	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		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1.00
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	2.00
3.00		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	3.00
4.00		0.00			4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

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

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	
B. 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		G	TLC MANAGEMENT	0.00	6.00
7.00				0.00	7.00
8.00				0.00	8.00
9.00				0.00	9.00
10.00				0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 152025

Period: From 09/01/2010 To 08/31/2011

Worksheet A-8-1

Date/Time Prepared: 2/13/2012 2:49 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	926	0	926	9		1.00
2.00	655	0	655	9		2.00
3.00	49,127	0	49,127	0		3.00
4.00	0	0	0	0		4.00
5.00	50,708	0	50,708			5.00
TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.						

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

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
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		0.00	MANAGEMENT COMP	6.00
7.00		0.00		7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet A-8-2

Date/Time Prepared:
2/13/2012 2:49 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	30.00	PHYSICIAN SALARIES	479,553	479,553	1.00
2.00	0.00		0	0	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (Lines 1.00 through 199.00)	479,553	479,553	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet A-8-2

Date/Time Prepared:
2/13/2012 2:49 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet A-8-2

Date/Time Prepared:
2/13/2012 2:49 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet A-8-2
Date/Time Prepared:
2/13/2012 2:49 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	479,553	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	479,553	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B
Part I
Date/Time Prepared:
2/13/2012 2:49 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00 CAP REL COSTS-MVBLE EQUIP	490,576		490,576			2.00
4.00 EMPLOYEE BENEFITS	512,040	0	0	512,040		4.00
5.00 ADMINISTRATIVE & GENERAL	711,584	0	50,944	95,362	857,890	5.00
6.00 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 OPERATION OF PLANT	42,162	0	0	0	42,162	7.00
8.00 LAUNDRY & LINEN SERVICE	47,670	0	0	72	47,742	8.00
9.00 HOUSEKEEPING	114,680	0	0	0	114,680	9.00
10.00 DIETARY	215,472	0	0	0	215,472	10.00
11.00 CAFETERIA	0	0	0	0	0	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	40,199	0	0	6,733	46,932	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	184,393	0	9,376	27,091	220,860	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,381,723	0	373,592	382,782	3,138,097	30.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	328,691	0	0	0	328,691	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	193,136	0	0	0	193,136	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	1,085,308	0	8,737	0	1,094,045	65.00
66.00 PHYSICAL THERAPY	48,574	0	4,732	0	53,306	66.00
67.00 OCCUPATIONAL THERAPY	41,350	0	4,732	0	46,082	67.00
68.00 SPEECH PATHOLOGY	23,992	0	4,703	0	28,695	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	397,847	0	33,760	0	431,607	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,540,266	0	0	0	1,540,266	73.00
74.00 RENAL DIALYSIS	141,684	0	0	0	141,684	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	534,851	0	0	0	534,851	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	9,076,198	0	490,576	512,040	9,076,198	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B
Part I
Date/Time Prepared:
2/13/2012 2:49 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
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)	9,076,198	0	490,576	512,040	9,076,198	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 152025		Period: From 09/01/2010 To 08/31/2011		Worksheet B Part I Date/Time Prepared: 2/13/2012 2:49 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	857,890					5.00
6.00	MAINTENANCE & REPAIRS	0	0				6.00
7.00	OPERATION OF PLANT	4,401	0	46,563			7.00
8.00	LAUNDRY & LINEN SERVICE	4,984	0	0	52,726		8.00
9.00	HOUSEKEEPING	11,971	0	0	0	126,651	9.00
10.00	DIETARY	22,493	0	0	0	0	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	4,899	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	23,055	0	993	0	2,701	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	327,578	0	39,569	52,726	107,626	30.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	34,311	0	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	20,161	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	114,205	0	925	0	2,517	65.00
66.00	PHYSICAL THERAPY	5,565	0	501	0	1,363	66.00
67.00	OCCUPATIONAL THERAPY	4,810	0	501	0	1,363	67.00
68.00	SPEECH PATHOLOGY	2,995	0	498	0	1,355	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,055	0	3,576	0	9,726	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	160,785	0	0	0	0	73.00
74.00	RENAL DIALYSIS	14,790	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	55,832	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	857,890	0	46,563	52,726	126,651	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
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)	857,890	0	46,563	52,726	126,651	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 152025		Period: From 09/01/2010 To 08/31/2011		Worksheet B Part I Date/Time Prepared: 2/13/2012 2:49 pm	
Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	237,965					10.00
11.00	CAFETERIA	0	0				11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	NURSING ADMINISTRATION	0	0	0	51,831		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	237,965	0	0	51,831	0	30.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	237,965	0	0	51,831	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
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)	237,965	0	0	51,831	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B
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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	
	15.00	16.00	17.00	18.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
12.00 MAINTENANCE OF PERSONNEL						12.00
13.00 NURSING ADMINISTRATION						13.00
14.00 CENTRAL SERVICES & SUPPLY						14.00
15.00 PHARMACY	0					15.00
16.00 MEDICAL RECORDS & LIBRARY	0	247,609				16.00
17.00 SOCIAL SERVICE	0	0	0			17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0		18.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	87,707	0	0	0	30.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	7,898	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	10,693	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	18,224	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	9,934	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	8,148	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	5,255	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	32,125	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	58,718	0	0	0	73.00
74.00 RENAL DIALYSIS	0	4,417	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	4,490	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	247,609	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B
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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	
		15.00	16.00	17.00	18.00	19.00
202.00 TOTAL (sum lines 118-201)	0	247,609	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT				1.00
2.00	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	EMPLOYEE BENEFITS				4.00
5.00	ADMINISTRATIVE & GENERAL				5.00
6.00	MAINTENANCE & REPAIRS				6.00
7.00	OPERATION OF PLANT				7.00
8.00	LAUNDRY & LINEN SERVICE				8.00
9.00	HOUSEKEEPING				9.00
10.00	DIETARY				10.00
11.00	CAFETERIA				11.00
12.00	MAINTENANCE OF PERSONNEL				12.00
13.00	NURSING ADMINISTRATION				13.00
14.00	CENTRAL SERVICES & SUPPLY				14.00
15.00	PHARMACY				15.00
16.00	MEDICAL RECORDS & LIBRARY				16.00
17.00	SOCIAL SERVICE				17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)				18.00
19.00	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	4,043,099	0	4,043,099	30.00
46.00	OTHER LONG TERM CARE	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	370,900	0	370,900	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	56.00
57.00	CT SCAN	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	LABORATORY	223,990	0	223,990	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	RESPIRATORY THERAPY	1,229,916	0	1,229,916	65.00
66.00	PHYSICAL THERAPY	70,669	0	70,669	66.00
67.00	OCCUPATIONAL THERAPY	60,904	0	60,904	67.00
68.00	SPEECH PATHOLOGY	38,798	0	38,798	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	522,089	0	522,089	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,759,769	0	1,759,769	73.00
74.00	RENAL DIALYSIS	160,891	0	160,891	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	CLINIC	0	0	0	90.00
91.00	EMERGENCY	595,173	0	595,173	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.00	CMHC	0	0	0	99.00
99.10	CORF	0	0	0	99.10
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
101.00	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	HOSPICE	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	9,076,198	0	9,076,198	118.00
NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00	RESEARCH	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	193.00
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152025

Period:
From 09/01/2010
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Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
202.00 TOTAL (sum lines 118-201)	9,076,198	0	9,076,198		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	0	50,944	50,944	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	OPERATION OF PLANT	0	0	0	0	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	HOUSEKEEPING	0	0	0	0	9.00
10.00	DIETARY	0	0	0	0	10.00
11.00	CAFETERIA	0	0	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	9,376	9,376	16.00
17.00	SOCIAL SERVICE	0	0	0	0	17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0	373,592	373,592	30.00
46.00	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	8,737	8,737	65.00
66.00	PHYSICAL THERAPY	0	0	4,732	4,732	66.00
67.00	OCCUPATIONAL THERAPY	0	0	4,732	4,732	67.00
68.00	SPEECH PATHOLOGY	0	0	4,703	4,703	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	33,760	33,760	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.00	CMHC	0	0	0	0	99.00
99.10	CORF	0	0	0	0	99.10
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
101.00	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	490,576	490,576	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
200.00	Cross Foot Adjustments	0	0	0	0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152025

Period:
From 09/01/2010
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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	2.00	2A	4.00	
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	0	490,576	490,576	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 152025		Period: From 09/01/2010 To 08/31/2011		Worksheet B Part II Date/Time Prepared: 2/13/2012 2:49 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	50,944					5.00
6.00	MAINTENANCE & REPAIRS	0	0				6.00
7.00	OPERATION OF PLANT	261	0	261			7.00
8.00	LAUNDRY & LINEN SERVICE	296	0	0	296		8.00
9.00	HOUSEKEEPING	711	0	0	0	711	9.00
10.00	DIETARY	1,336	0	0	0	0	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	291	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,369	0	6	0	15	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	19,451	0	221	296	603	30.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,038	0	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	1,197	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	6,782	0	5	0	14	65.00
66.00	PHYSICAL THERAPY	330	0	3	0	8	66.00
67.00	OCCUPATIONAL THERAPY	286	0	3	0	8	67.00
68.00	SPEECH PATHOLOGY	178	0	3	0	8	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,676	0	20	0	55	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	9,548	0	0	0	0	73.00
74.00	RENAL DIALYSIS	878	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	3,316	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	50,944	0	261	296	711	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
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)	50,944	0	261	296	711	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B
Part II
Date/Time Prepared:
2/13/2012 2:49 pm

Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
	10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	1,336					10.00
11.00 CAFETERIA	0	0				11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00 NURSING ADMINISTRATION	0	0	0	291		13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,336	0	0	291	0	30.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,336	0	0	291	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
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)	1,336	0	0	291	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	
	15.00	16.00	17.00	18.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
12.00 MAINTENANCE OF PERSONNEL						12.00
13.00 NURSING ADMINISTRATION						13.00
14.00 CENTRAL SERVICES & SUPPLY						14.00
15.00 PHARMACY	0					15.00
16.00 MEDICAL RECORDS & LIBRARY	0	10,766				16.00
17.00 SOCIAL SERVICE	0	0	0			17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0		18.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	3,811	0	0		30.00
46.00 OTHER LONG TERM CARE	0	0	0	0		46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0		50.00
51.00 RECOVERY ROOM	0	0	0	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00 ANESTHESIOLOGY	0	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	344	0	0		54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0		55.00
56.00 RADIOISOTOPE	0	0	0	0		56.00
57.00 CT SCAN	0	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00 LABORATORY	0	465	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0	0		60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0		61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0	793	0	0		65.00
66.00 PHYSICAL THERAPY	0	432	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	354	0	0		67.00
68.00 SPEECH PATHOLOGY	0	229	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,397	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	2,554	0	0		73.00
74.00 RENAL DIALYSIS	0	192	0	0		74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0		75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00 CLINIC	0	0	0	0		90.00
91.00 EMERGENCY	0	195	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
99.00 CMHC	0	0	0	0		99.00
99.10 CORF	0	0	0	0		99.10
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00 HOME HEALTH AGENCY	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	10,766	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00 RESEARCH	0	0	0	0		191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00 NONPAID WORKERS	0	0	0	0		193.00
200.00 Cross Foot Adjustments						0200.00
201.00 Negative Cost Centers	0	0	0	0		0201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 152025		Period: From 09/01/2010 To 08/31/2011		Worksheet B Part II Date/Time Prepared: 2/13/2012 2:49 pm	
Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS		
	15.00	16.00	17.00	18.00	19.00		
202.00 TOTAL (sum lines 118-201)	0	10,766	0	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B
Part II
Date/Time Prepared:
2/13/2012 2:49 pm

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00 CAP REL COSTS-BLDG & FIXT				1.00
2.00 CAP REL COSTS-MVBLE EQUIP				2.00
4.00 EMPLOYEE BENEFITS				4.00
5.00 ADMINISTRATIVE & GENERAL				5.00
6.00 MAINTENANCE & REPAIRS				6.00
7.00 OPERATION OF PLANT				7.00
8.00 LAUNDRY & LINEN SERVICE				8.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
12.00 MAINTENANCE OF PERSONNEL				12.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY				15.00
16.00 MEDICAL RECORDS & LIBRARY				16.00
17.00 SOCIAL SERVICE				17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)				18.00
19.00 NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	399,601	0	399,601	30.00
46.00 OTHER LONG TERM CARE	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	2,382	0	2,382	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	56.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	1,662	0	1,662	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 RESPIRATORY THERAPY	16,331	0	16,331	65.00
66.00 PHYSICAL THERAPY	5,505	0	5,505	66.00
67.00 OCCUPATIONAL THERAPY	5,383	0	5,383	67.00
68.00 SPEECH PATHOLOGY	5,121	0	5,121	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	37,908	0	37,908	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	12,102	0	12,102	73.00
74.00 RENAL DIALYSIS	1,070	0	1,070	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 CLINIC	0	0	0	90.00
91.00 EMERGENCY	3,511	0	3,511	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
99.00 CMHC	0	0	0	99.00
99.10 CORF	0	0	0	99.10
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
116.00 HOSPICE	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	490,576	0	490,576	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00 RESEARCH	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	193.00
200.00 Cross Foot Adjustments	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet B Part II Date/Time Prepared: 2/13/2012 2:49 pm
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Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24.00	25.00	26.00		
202.00 TOTAL (sum lines 118-201)	490,576	0	490,576		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B-1

Date/Time Prepared:
2/13/2012 2:49 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (DOLLAR VALUE)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP		16,900			2.00
4.00	EMPLOYEE BENEFITS	0	0	3,057,123		4.00
5.00	ADMINISTRATIVE & GENERAL	0	1,755	569,353	-857,890	8,218,308
6.00	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	OPERATION OF PLANT	0	0	0	0	42,162
8.00	LAUNDRY & LINEN SERVICE	0	0	430	0	47,742
9.00	HOUSEKEEPING	0	0	0	0	114,680
10.00	DIETARY	0	0	0	0	215,472
11.00	CAFETERIA	0	0	0	0	0
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	NURSING ADMINISTRATION	0	0	40,199	0	46,932
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	PHARMACY	0	0	0	0	0
16.00	MEDICAL RECORDS & LIBRARY	0	323	161,746	0	220,860
17.00	SOCIAL SERVICE	0	0	0	0	0
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	12,870	2,285,395	0	3,138,097
46.00	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0
51.00	RECOVERY ROOM	0	0	0	0	0
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	ANESTHESIOLOGY	0	0	0	0	0
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	328,691
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	RADIOISOTOPE	0	0	0	0	0
57.00	CT SCAN	0	0	0	0	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	LABORATORY	0	0	0	0	193,136
60.01	BLOOD LABORATORY	0	0	0	0	0
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	RESPIRATORY THERAPY	0	301	0	0	1,094,045
66.00	PHYSICAL THERAPY	0	163	0	0	53,306
67.00	OCCUPATIONAL THERAPY	0	163	0	0	46,082
68.00	SPEECH PATHOLOGY	0	162	0	0	28,695
69.00	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,163	0	0	431,607
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,540,266
74.00	RENAL DIALYSIS	0	0	0	0	141,684
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	CLINIC	0	0	0	0	0
91.00	EMERGENCY	0	0	0	0	534,851
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.00	CMHC	0	0	0	0	0
99.10	CORF	0	0	0	0	0
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	16,900	3,057,123	-857,890	8,218,308
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	RESEARCH	0	0	0	0	0
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00	NONPAID WORKERS	0	0	0	0	0
200.00	Cross Foot Adjustments	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B-1

Date/Time Prepared:
2/13/2012 2:49 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (DOLLAR VALUE)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	0	490,576	512,040		857,890	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	29.028166	0.167491		0.104388	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			0		50,944	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000000		0.006199	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B-1

Date/Time Prepared:
2/13/2012 2:49 pm

Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
	6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS	0					6.00
7.00 OPERATION OF PLANT	0	15,145				7.00
8.00 LAUNDRY & LINEN SERVICE	0	0	100			8.00
9.00 HOUSEKEEPING	0	0	0	15,145		9.00
10.00 DIETARY	0	0	0	0	100	10.00
11.00 CAFETERIA	0	0	0	0	0	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	323	0	323	0	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	12,870	100	12,870	100	30.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	301	0	301	0	65.00
66.00 PHYSICAL THERAPY	0	163	0	163	0	66.00
67.00 OCCUPATIONAL THERAPY	0	163	0	163	0	67.00
68.00 SPEECH PATHOLOGY	0	162	0	162	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,163	0	1,163	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	15,145	100	15,145	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
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)	0	46,563	52,726	126,651	237,965	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B-1

Date/Time Prepared:
2/13/2012 2:49 pm

Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
	6.00	7.00	8.00	9.00	10.00	
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	3.074480	527.260000	8.362562	2,379.650000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	261	296	711	1,336	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	0.017233	2.960000	0.046946	13.360000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B-1

Date/Time Prepared:
2/13/2012 2:49 pm

Cost Center Description	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
	11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	0					11.00
12.00 MAINTENANCE OF PERSONNEL	0	0				12.00
13.00 NURSING ADMINISTRATION	0	0	100			13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	0	100	0	0	30.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	100	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B-1

Date/Time Prepared:
2/13/2012 2:49 pm

Cost Center Description	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
	11.00	12.00	13.00	14.00	15.00	
202.00 Cost to be allocated (per Wkst. B, Part I)	0	0	51,831	0	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	518.310000	0.000000	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	0	291	0	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	2.910000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B-1
Date/Time Prepared:
2/13/2012 2:49 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
	16.00	17.00	18.00	19.00	
GENERAL SERVICE COST CENTERS					
1.00 CAP REL COSTS-BLDG & FIXT					1.00
2.00 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.00 ADMINISTRATIVE & GENERAL					5.00
6.00 MAINTENANCE & REPAIRS					6.00
7.00 OPERATION OF PLANT					7.00
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
12.00 MAINTENANCE OF PERSONNEL					12.00
13.00 NURSING ADMINISTRATION					13.00
14.00 CENTRAL SERVICES & SUPPLY					14.00
15.00 PHARMACY					15.00
16.00 MEDICAL RECORDS & LIBRARY	23,212,097				16.00
17.00 SOCIAL SERVICE	0	0			17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0		18.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	8,221,729	0	0		30.00
46.00 OTHER LONG TERM CARE	0	0	0		46.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	740,425	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 LABORATORY	1,002,453	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	1,708,422	0	0	0	65.00
66.00 PHYSICAL THERAPY	931,248	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	763,834	0	0	0	67.00
68.00 SPEECH PATHOLOGY	492,687	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,011,664	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	5,504,634	0	0	0	73.00
74.00 RENAL DIALYSIS	414,109	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	90.00
91.00 EMERGENCY	420,892	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS					
99.00 CMHC	0	0	0	0	99.00
99.10 CORF	0	0	0	0	99.10
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
116.00 HOSPICE	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	23,212,097	0	0	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	193.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet B-1

Date/Time Prepared:
2/13/2012 2:49 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
	16.00	17.00	18.00	19.00		
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	247,609	0	0	0		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.010667	0.000000	0.000000	0.000000		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	10,766	0	0	0		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000464	0.000000	0.000000	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet C
Part I
Date/Time Prepared:
2/13/2012 2:49 pm

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		4,043,099	0	4,043,099	30.00
46.00	OTHER LONG TERM CARE		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		0	0	0	50.00
51.00	RECOVERY ROOM		0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	ANESTHESIOLOGY		0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC		370,900	0	370,900	54.00
55.00	RADIOLOGY-THERAPEUTIC		0	0	0	55.00
56.00	RADIOISOTOPE		0	0	0	56.00
57.00	CT SCAN		0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	LABORATORY		223,990	0	223,990	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.		0	0	0	63.00
64.00	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	1,229,916	0	1,229,916	65.00
66.00	PHYSICAL THERAPY	0	70,669	0	70,669	66.00
67.00	OCCUPATIONAL THERAPY	0	60,904	0	60,904	67.00
68.00	SPEECH PATHOLOGY	0	38,798	0	38,798	68.00
69.00	ELECTROCARDIOLOGY		0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		522,089	0	522,089	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		1,759,769	0	1,759,769	73.00
74.00	RENAL DIALYSIS		160,891	0	160,891	74.00
75.00	ASC (NON-DISTINCT PART)		0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	CLINIC		0	0	0	90.00
91.00	EMERGENCY		595,173	0	595,173	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.00	CMHC		0	0	0	99.00
99.10	CORF		0	0	0	99.10
100.00	I&R SERVICES-NOT APPRVD PRGM		0	0	0	100.00
101.00	HOME HEALTH AGENCY		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE		0	0	0	116.00
200.00	Subtotal (see instructions)		9,076,198	0	9,076,198	200.00
201.00	Less Observation Beds		0	0	0	201.00
202.00	Total (see instructions)		9,076,198	0	9,076,198	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet C Part I Date/Time Prepared: 2/13/2012 2:49 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	8,221,729		8,221,729			30.00
46.00 OTHER LONG TERM CARE	0		0			46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
51.00 RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 RADIOLOGY-DIAGNOSTIC	740,425	0	740,425	0.500929	0.000000	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00 RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00 LABORATORY	1,002,453	0	1,002,453	0.223442	0.000000	60.00
60.01 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00 RESPIRATORY THERAPY	1,708,422	0	1,708,422	0.719913	0.000000	65.00
66.00 PHYSICAL THERAPY	931,248	0	931,248	0.075886	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	763,834	0	763,834	0.079735	0.000000	67.00
68.00 SPEECH PATHOLOGY	492,687	0	492,687	0.078748	0.000000	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,011,664	0	3,011,664	0.173356	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	5,504,634	0	5,504,634	0.319689	0.000000	73.00
74.00 RENAL DIALYSIS	414,109	0	414,109	0.388523	0.000000	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0			88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00 CLINIC	0	0	0	0.000000	0.000000	90.00
91.00 EMERGENCY	420,892	0	420,892	1.414075	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
99.00 CMHC	0	0	0			99.00
99.10 CORF	0	0	0			99.10
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
101.00 HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0			116.00
200.00 Subtotal (see instructions)	23,212,097	0	23,212,097			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	23,212,097	0	23,212,097			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet C Part I Date/Time Prepared: 2/13/2012 2:49 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	ADULTS & PEDIATRICS			30.00
46.00	OTHER LONG TERM CARE			46.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.000000		50.00
51.00	RECOVERY ROOM	0.000000		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.500929		54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	RADIOISOTOPE	0.000000		56.00
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.223442		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	INTRAVENOUS THERAPY	0.000000		64.00
65.00	RESPIRATORY THERAPY	0.719913		65.00
66.00	PHYSICAL THERAPY	0.075886		66.00
67.00	OCCUPATIONAL THERAPY	0.079735		67.00
68.00	SPEECH PATHOLOGY	0.078748		68.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173356		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.319689		73.00
74.00	RENAL DIALYSIS	0.388523		74.00
75.00	ASC (NON-DISTINCT PART)	0.000000		75.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	CLINIC	0.000000		90.00
91.00	EMERGENCY	1.414075		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
	OTHER REIMBURSABLE COST CENTERS			
99.00	CMHC			99.00
99.10	CORF			99.10
100.00	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
116.00	HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet C
Part I
Date/Time Prepared:
2/13/2012 2:49 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		4,043,099	0	0	30.00
46.00	OTHER LONG TERM CARE		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		0	0	0	50.00
51.00	RECOVERY ROOM		0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	ANESTHESIOLOGY		0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC		370,900	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC		0	0	0	55.00
56.00	RADIOISOTOPE		0	0	0	56.00
57.00	CT SCAN		0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	LABORATORY		223,990	0	0	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.		0	0	0	63.00
64.00	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	1,229,916	0	0	65.00
66.00	PHYSICAL THERAPY	0	70,669	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	60,904	0	0	67.00
68.00	SPEECH PATHOLOGY	0	38,798	0	0	68.00
69.00	ELECTROCARDIOLOGY		0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		522,089	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		1,759,769	0	0	73.00
74.00	RENAL DIALYSIS		160,891	0	0	74.00
75.00	ASC (NON-DISTINCT PART)		0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	CLINIC		0	0	0	90.00
91.00	EMERGENCY		595,173	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.00	CMHC		0	0	0	99.00
99.10	CORF		0	0	0	99.10
100.00	I&R SERVICES-NOT APPRVD PRGM		0	0	0	100.00
101.00	HOME HEALTH AGENCY		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE		0	0	0	116.00
200.00	Subtotal (see instructions)		9,076,198	0	0	200.00
201.00	Less Observation Beds		0	0	0	201.00
202.00	Total (see instructions)		9,076,198	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet C
Part I
Date/Time Prepared:
2/13/2012 2:49 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	ADULTS & PEDIATRICS	8,221,729		8,221,729			30.00
46.00	OTHER LONG TERM CARE	0		0			46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
51.00	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	740,425	0	740,425	0.500929	0.000000	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	1,002,453	0	1,002,453	0.223442	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	RESPIRATORY THERAPY	1,708,422	0	1,708,422	0.719913	0.000000	65.00
66.00	PHYSICAL THERAPY	931,248	0	931,248	0.075886	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	763,834	0	763,834	0.079735	0.000000	67.00
68.00	SPEECH PATHOLOGY	492,687	0	492,687	0.078748	0.000000	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,011,664	0	3,011,664	0.173356	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,504,634	0	5,504,634	0.319689	0.000000	73.00
74.00	RENAL DIALYSIS	414,109	0	414,109	0.388523	0.000000	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	EMERGENCY	420,892	0	420,892	1.414075	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	CMHC	0	0	0			99.00
99.10	CORF	0	0	0			99.10
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
101.00	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	0	0	0			116.00
200.00	Subtotal (see instructions)	23,212,097	0	23,212,097			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	23,212,097	0	23,212,097			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet C Part I Date/Time Prepared: 2/13/2012 2:49 pm
		Title XIX	Hospital	Cost

Cost Center Description	PPS Inpatient Ratio		
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS			30.00
46.00 OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0.000000		50.00
51.00 RECOVERY ROOM	0.000000		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00 ANESTHESIOLOGY	0.000000		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00 RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00 RADIOISOTOPE	0.000000		56.00
57.00 CT SCAN	0.000000		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00 CARDIAC CATHETERIZATION	0.000000		59.00
60.00 LABORATORY	0.000000		60.00
60.01 BLOOD LABORATORY	0.000000		60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00 INTRAVENOUS THERAPY	0.000000		64.00
65.00 RESPIRATORY THERAPY	0.000000		65.00
66.00 PHYSICAL THERAPY	0.000000		66.00
67.00 OCCUPATIONAL THERAPY	0.000000		67.00
68.00 SPEECH PATHOLOGY	0.000000		68.00
69.00 ELECTROCARDIOLOGY	0.000000		69.00
70.00 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00 RENAL DIALYSIS	0.000000		74.00
75.00 ASC (NON-DISTINCT PART)	0.000000		75.00
OUTPATIENT SERVICE COST CENTERS			
88.00 RURAL HEALTH CLINIC	0.000000		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00 CLINIC	0.000000		90.00
91.00 EMERGENCY	0.000000		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS			
99.00 CMHC			99.00
99.10 CORF			99.10
100.00 I&R SERVICES-NOT APPRVD PRGM			100.00
101.00 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS			
116.00 HOSPICE			116.00
200.00 Subtotal (see instructions)			200.00
201.00 Less Observation Beds			201.00
202.00 Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 152025		Period: From 09/01/2010 To 08/31/2011		Worksheet D Part I Date/Time Prepared: 2/13/2012 2:49 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description		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	ADULTS & PEDIATRICS	399,601	0	399,601	6,771	59.02	30.00
200.00	Total (lines 30-199)	399,601		399,601	6,771		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 152025		Period: From 09/01/2010 To 08/31/2011	Worksheet D Part I Date/Time Prepared: 2/13/2012 2:49 pm
			Title XVIII	Hospital	PPS
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	5,277	311,449		
200.00	Total (Lines 30-199)	5,277	311,449		30.00 200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet D Part II Date/Time Prepared: 2/13/2012 2:49 pm
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Cost Center Description		Title XVIII			Hospital	PPS	
		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	OPERATING ROOM	0	0	0.000000	0	0	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,382	740,425	0.003217	446,208	1,435	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	1,662	1,002,453	0.001658	484,438	803	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	16,331	1,708,422	0.009559	1,278,599	12,222	65.00
66.00	PHYSICAL THERAPY	5,505	931,248	0.005911	641,178	3,790	66.00
67.00	OCCUPATIONAL THERAPY	5,383	763,834	0.007047	544,748	3,839	67.00
68.00	SPEECH PATHOLOGY	5,121	492,687	0.010394	373,931	3,887	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,908	3,011,664	0.012587	2,117,257	26,650	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	12,102	5,504,634	0.002199	4,026,158	8,854	73.00
74.00	RENAL DIALYSIS	1,070	414,109	0.002584	322,291	833	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	0	0	0.000000	0	0	90.00
91.00	EMERGENCY	3,511	420,892	0.008342	306,485	2,557	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
200.00	Total (Lines 50-199)	90,975	14,990,368		10,541,293	64,870	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152025		Period: From 09/01/2010 To 08/31/2011		Worksheet D Part III Date/Time Prepared: 2/13/2012 2:49 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
		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	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00	Total (Lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152025		Period: From 09/01/2010 To 08/31/2011		Worksheet D Part III Date/Time Prepared: 2/13/2012 2:49 pm	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	PPS
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,771	0.00	5,277	0	0	30.00
200.00	Total (Lines 30-199)	6,771		5,277	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152025		Period: From 09/01/2010 To 08/31/2011	Worksheet D Part III Date/Time Prepared: 2/13/2012 2:49 pm
			Title XVIII	Hospital	PPS
Cost Center Description	PSA Adj . Allied Health Cost	PSA Adj . All Other Medical Education Cost			
	12.00	13.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDI ATRICS	0	0		
200.00	Total (lines 30-199)	0	0	30.00 200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet D Part IV Date/Time Prepared: 2/13/2012 2:49 pm
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00	Total (Lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet D Part IV Date/Time Prepared: 2/13/2012 2:49 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)	Hospital		Inpatient Program Charges	PPS
				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
	6.00	7.00	8.00	9.00		10.00	
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0.000000	0.000000		0	50.00
51.00 RECOVERY ROOM	0	0	0.000000	0.000000		0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000		0	52.00
53.00 ANESTHESIOLOGY	0	0	0.000000	0.000000		0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	740,425	0.000000	0.000000		446,208	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000		0	55.00
56.00 RADIOISOTOPE	0	0	0.000000	0.000000		0	56.00
57.00 CT SCAN	0	0	0.000000	0.000000		0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000		0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000		0	59.00
60.00 LABORATORY	0	1,002,453	0.000000	0.000000		484,438	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000		0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000		0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000		0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000		0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0.000000	0.000000		0	64.00
65.00 RESPIRATORY THERAPY	0	1,708,422	0.000000	0.000000		1,278,599	65.00
66.00 PHYSICAL THERAPY	0	931,248	0.000000	0.000000		641,178	66.00
67.00 OCCUPATIONAL THERAPY	0	763,834	0.000000	0.000000		544,748	67.00
68.00 SPEECH PATHOLOGY	0	492,687	0.000000	0.000000		373,931	68.00
69.00 ELECTROCARDIOLOGY	0	0	0.000000	0.000000		0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000		0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,011,664	0.000000	0.000000		2,117,257	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000		0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	5,504,634	0.000000	0.000000		4,026,158	73.00
74.00 RENAL DIALYSIS	0	414,109	0.000000	0.000000		322,291	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000		0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0.000000	0.000000		0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000		0	89.00
90.00 CLINIC	0	0	0.000000	0.000000		0	90.00
91.00 EMERGENCY	0	420,892	0.000000	0.000000		306,485	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000		0	92.00
200.00 Total (Lines 50-199)	0	14,990,368				10,541,293	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet D Part IV Date/Time Prepared: 2/13/2012 2:49 pm
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Cost Center Description		Title XVIII			Hospital		PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet D Part IV Date/Time Prepared: 2/13/2012 2:49 pm
Title XVIII		Hospital	PPS

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
	23.00	24.00	
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0	0	50.00
51.00 RECOVERY ROOM	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00 RADIOISOTOPE	0	0	56.00
57.00 CT SCAN	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	59.00
60.00 LABORATORY	0	0	60.00
60.01 BLOOD LABORATORY	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 RENAL DIALYSIS	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS			
88.00 RURAL HEALTH CLINIC	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00 CLINIC	0	0	90.00
91.00 EMERGENCY	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Total (Lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 152025		Period: From 09/01/2010 To 08/31/2011		Worksheet D Part I Date/Time Prepared: 2/13/2012 2:49 pm	
			Title XIX		Hospital		Cost	
Cost Center Description		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	ADULTS & PEDIATRICS	399,601	0	399,601	6,771	59.02	30.00	
200.00	Total (lines 30-199)	399,601		399,601	6,771		200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 152025		Period: From 09/01/2010 To 08/31/2011	Worksheet D Part I Date/Time Prepared: 2/13/2012 2:49 pm
			Title XIX	Hospital	Cost
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	29	1,712	30.00	
200.00	Total (Lines 30-199)	29	1,712	200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet D Part II Date/Time Prepared: 2/13/2012 2:49 pm
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Cost Center Description		Title XIX			Hospital		Cost		
		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	OPERATING ROOM	0	0	0.000000	0	0	0	50.00	
51.00	RECOVERY ROOM	0	0	0.000000	0	0	0	51.00	
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	0	52.00	
53.00	ANESTHESIOLOGY	0	0	0.000000	0	0	0	53.00	
54.00	RADIOLOGY-DIAGNOSTIC	2,382	740,425	0.003217	0	0	0	54.00	
55.00	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	0	55.00	
56.00	RADIOISOTOPE	0	0	0.000000	0	0	0	56.00	
57.00	CT SCAN	0	0	0.000000	0	0	0	57.00	
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	0	58.00	
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	0	59.00	
60.00	LABORATORY	1,662	1,002,453	0.001658	864	1	60.00		
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01		
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00		
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00		
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00		
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00		
65.00	RESPIRATORY THERAPY	16,331	1,708,422	0.009559	1,458	14	65.00		
66.00	PHYSICAL THERAPY	5,505	931,248	0.005911	7,029	42	66.00		
67.00	OCCUPATIONAL THERAPY	5,383	763,834	0.007047	1,683	12	67.00		
68.00	SPEECH PATHOLOGY	5,121	492,687	0.010394	2,129	22	68.00		
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00		
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00		
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,908	3,011,664	0.012587	11,951	150	71.00		
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00		
73.00	DRUGS CHARGED TO PATIENTS	12,102	5,504,634	0.002199	6,098	13	73.00		
74.00	RENAL DIALYSIS	1,070	414,109	0.002584	0	0	74.00		
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00		
OUTPATIENT SERVICE COST CENTERS									
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00		
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00		
90.00	CLINIC	0	0	0.000000	0	0	90.00		
91.00	EMERGENCY	3,511	420,892	0.008342	0	0	91.00		
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00		
200.00	Total (Lines 50-199)	90,975	14,990,368		31,212	254	200.00		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152025		Period: From 09/01/2010 To 08/31/2011		Worksheet D Part III Date/Time Prepared: 2/13/2012 2:49 pm	
Cost Center Description		Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	Cost 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	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00	Total (Lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152025		Period: From 09/01/2010 To 08/31/2011		Worksheet D Part III Date/Time Prepared: 2/13/2012 2:49 pm	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	Cost
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,771	0.00	29	0	0	30.00
200.00	Total (Lines 30-199)	6,771		29	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152025		Period: From 09/01/2010 To 08/31/2011	Worksheet D Part III Date/Time Prepared: 2/13/2012 2:49 pm
Title XIX			Hospital		Cost
Cost Center Description	PSA Adj . Allied Health Cost	PSA Adj . All Other Medical Education Cost			
	12.00	13.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDI ATRICS	0	0		30.00
200.00	Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet D Part IV Date/Time Prepared: 2/13/2012 2:49 pm
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Cost Center Description	Title XIX				Hospital	Cost	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00 Total (Lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet D
Part IV
Date/Time Prepared:
2/13/2012 2:49 pm

Cost Center Description		Title XIX			Hospital		Cost
		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	OPERATING ROOM	0	0	0.000000	0.000000	0	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	740,425	0.000000	0.000000	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	1,002,453	0.000000	0.000000	864	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	1,708,422	0.000000	0.000000	1,458	65.00
66.00	PHYSICAL THERAPY	0	931,248	0.000000	0.000000	7,029	66.00
67.00	OCCUPATIONAL THERAPY	0	763,834	0.000000	0.000000	1,683	67.00
68.00	SPEECH PATHOLOGY	0	492,687	0.000000	0.000000	2,129	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,011,664	0.000000	0.000000	11,951	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	5,504,634	0.000000	0.000000	6,098	73.00
74.00	RENAL DIALYSIS	0	414,109	0.000000	0.000000	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	420,892	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
200.00	Total (Lines 50-199)	0	14,990,368			31,212	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet D Part IV Date/Time Prepared: 2/13/2012 2:49 pm
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Cost Center Description	Title XIX			Hospital	Cost		
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
	11.00	12.00	13.00	21.00	22.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00 Total (Lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet D Part IV Date/Time Prepared: 2/13/2012 2:49 pm
	Title XIX	Hospital	Cost

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost		
	23.00	24.00		
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0	50.00
51.00	RECOVERY ROOM	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	RADIOISOTOPE	0	0	56.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	0	60.00
60.01	BLOOD LABORATORY	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	RENAL DIALYSIS	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	CLINIC	0	0	90.00
91.00	EMERGENCY	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (Lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/13/2012 2:49 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)		6,771	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,771	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,771	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)		5,277	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)		4,043,099	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)		4,043,099	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		8,221,729	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		8,221,729	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.491758	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)		1,214.26	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)		4,043,099	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)		597.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,151,002	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,151,002	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet D-1 Date/Time Prepared: 2/13/2012 2:49 pm	
Cost Center Description			Title XVIII		Hospital	PPS
	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					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)				3,586,547	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				6,737,549	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)				311,449	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				64,870	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				376,319	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				6,361,230	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: 152025		Period: From 09/01/2010 To 08/31/2011		Worksheet D-1 Date/Time Prepared: 2/13/2012 2:49 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	399,601	4,043,099	0.098835	0	0	90.00
91.00	Nursing School cost	0	4,043,099	0.000000	0	0	91.00
92.00	Allied health cost	0	4,043,099	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,043,099	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 2/13/2012 2:49 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)		6,771	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,771	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,771	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)		29	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)		4,043,099	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)		4,043,099	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		8,221,729	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		8,221,729	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.491758	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)		1,214.26	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)		4,043,099	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)		597.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		17,316	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)		17,316	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet D-1 Date/Time Prepared: 2/13/2012 2:49 pm
Cost Center Description			Title XIX	Hospital	Cost
	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				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)				6,099 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				23,415 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: 152025		Period: From 09/01/2010 To 08/31/2011		Worksheet D-1 Date/Time Prepared: 2/13/2012 2:49 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet D-3 Date/Time Prepared: 2/13/2012 2:49 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		6,295,535		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000	0	0	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.500929	446,208	223,519	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	RADIOISOTOPE	0.000000	0	0	56.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.223442	484,438	108,244	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.719913	1,278,599	920,480	65.00
66.00	PHYSICAL THERAPY	0.075886	641,178	48,656	66.00
67.00	OCCUPATIONAL THERAPY	0.079735	544,748	43,435	67.00
68.00	SPEECH PATHOLOGY	0.078748	373,931	29,446	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173356	2,117,257	367,039	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.319689	4,026,158	1,287,118	73.00
74.00	RENAL DIALYSIS	0.388523	322,291	125,217	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	1.414075	306,485	433,393	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		10,541,293	3,586,547	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)		10,541,293		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet D-3 Date/Time Prepared: 2/13/2012 2:49 pm
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Cost Center Description	Title XIX		Hospital		Cost
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)		
	1.00	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS		13,775			30.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.000000	0	0	0	50.00
51.00 RECOVERY ROOM	0.000000	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00 ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.500929	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00 RADIOISOTOPE	0.000000	0	0	0	56.00
57.00 CT SCAN	0.000000	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00 LABORATORY	0.223442	864	193	60.00	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0.719913	1,458	1,050	65.00	65.00
66.00 PHYSICAL THERAPY	0.075886	7,029	533	66.00	66.00
67.00 OCCUPATIONAL THERAPY	0.079735	1,683	134	67.00	67.00
68.00 SPEECH PATHOLOGY	0.078748	2,129	168	68.00	68.00
69.00 ELECTROCARDIOLOGY	0.000000	0	0	69.00	69.00
70.00 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173356	11,951	2,072	71.00	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.319689	6,098	1,949	73.00	73.00
74.00 RENAL DIALYSIS	0.388523	0	0	74.00	74.00
75.00 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000	0	0	88.00	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00	89.00
90.00 CLINIC	0.000000	0	0	90.00	90.00
91.00 EMERGENCY	1.414075	0	0	91.00	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00	92.00
200.00 Total (sum of lines 50-94 and 96-98)		31,212	6,099	200.00	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00	201.00
202.00 Net Charges (line 200 minus line 201)		31,212	0	202.00	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet E Part B Date/Time Prepared: 2/13/2012 2:49 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			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)			0 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			0 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			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)			0 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)			0 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			0 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)			0 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)			0 40.00
41.00	Interim payments			0 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)			0 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet E Part B Date/Time Prepared: 2/13/2012 2:49 pm
		Title XVIII	Hospital
WORKSHEET OVERRIDE VALUES			PPS Overrides
			1.00
112.00 Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 152025		Period: From 09/01/2010 To 08/31/2011		Worksheet E-1 Part I Date/Time Prepared: 2/13/2012 2:49 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		7,922,997		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		58,368		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)		-58,368		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)		7,864,629		0		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		106,540		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		7,971,169		0		7.00
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet E-3 Part IV Date/Time Prepared: 2/13/2012 2:49 pm
		Title XVIII	Hospital	PPS
				1.00
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)			7,213,836 1.00
2.00	Outlier Payments			984,556 2.00
3.00	Total PPS Payments (sum of lines 1 and 2)			8,198,392 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)			8,198,392 7.00
8.00	Primary payer payments			0 8.00
9.00	Subtotal (line 7 less line 8)			8,198,392 9.00
10.00	Deductibles			17,888 10.00
11.00	Subtotal (line 9 minus line 10)			8,180,504 11.00
12.00	Coinsurance			340,927 12.00
13.00	Subtotal (line 11 minus line 12)			7,839,577 13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			187,989 14.00
15.00	Adjusted reimbursable bad debts (see instructions)			131,592 15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			187,989 16.00
17.00	Subtotal (sum of lines 13 and 15)			7,971,169 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)			7,971,169 22.00
23.00	Interim payments			7,864,629 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)			106,540 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: 152025	Period: From 09/01/2010 To 08/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 2/13/2012 2:49 pm
		Title XIX	Hospital	Cost
				1.00
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		23,415	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)		23,415	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)		23,415	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		13,775	8.00
9.00	Ancillary service charges		31,212	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)		44,987	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		44,987	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		21,572	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		23,415	21.00
PROSPECTIVE PAYMENT AMOUNT				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26, plus line 3 minus lines 5 and 6)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		23,415	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		23,415	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		23,415	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		23,415	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)		23,415	40.00
41.00	Interim payments		0	41.00
42.00	Balance due provider/program (line 40 minus 41)		23,415	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: 152025 Period: From 09/01/2010 To 08/31/2011 Worksheet G
 Date/Time Prepared: 2/13/2012 2:49 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	218,995	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	2,341,946	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-169,063	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	16,432	0	0	0	8.00
9.00	Other current assets	8,600	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)	2,416,910	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	136,948	0	0	0	17.00
18.00	Accumulated depreciation	-29,061	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	58,201	0	0	0	23.00
24.00	Accumulated depreciation	-39,783	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)	126,305	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	2,543,215	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,679,437	0	0	0	37.00
38.00	Salaries, wages, and fees payable	131,047	0	0	0	38.00
39.00	Payroll taxes payable	20,287	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	84,524	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,915,295	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	2,302,105	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,302,105	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,217,400	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-1,674,185				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)	-1,674,185	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	2,543,215	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet G-1

Date/Time Prepared:
2/13/2012 2:49 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		-2,261,765	
2.00	Net income (loss) (From Wkst. G-3, line 29)		587,580			2.00
3.00	Total (sum of line 1 and line 2)		-1,674,185		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		-1,674,185		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,674,185		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet G-1

Date/Time Prepared:
2/13/2012 2:49 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00			0		0	1.00
2.00						2.00
3.00			0		0	3.00
4.00	0			0		4.00
5.00	0			0		5.00
6.00	0			0		6.00
7.00	0			0		7.00
8.00	0			0		8.00
9.00	0			0		9.00
10.00			0		0	10.00
11.00			0		0	11.00
12.00	0			0		12.00
13.00	0			0		13.00
14.00	0			0		14.00
15.00	0			0		15.00
16.00	0			0		16.00
17.00	0			0		17.00
18.00			0		0	18.00
19.00			0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet G-2 Parts

Date/Time Prepared:
2/13/2012 2:49 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	10,449,108		10,449,108	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	10,449,108		10,449,108	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,449,108		10,449,108	17.00
18.00	Ancillary services	14,990,367	0	14,990,367	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	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)	25,439,475	0	25,439,475	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		9,548,989		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)		9,548,989		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 152025

Period:
From 09/01/2010
To 08/31/2011

Worksheet G-3

Date/Time Prepared:
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	25,439,475	1.00
2.00	Less contractual allowances and discounts on patients' accounts	15,621,697	2.00
3.00	Net patient revenues (line 1 minus line 2)	9,817,778	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	9,548,989	4.00
5.00	Net income from service to patients (line 3 minus line 4)	268,789	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	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	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	280	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	PHYSICIAN VISITS	291,604	24.00
24.01	MISCELLANEOUS	26,907	24.01
25.00	Total other income (sum of lines 6-24)	318,791	25.00
26.00	Total (line 5 plus line 25)	587,580	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	587,580	29.00