This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure 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: 140120	Period: From 05/01/2011 To 04/30/2012	Worksheet S Parts I-III Date/Time Prepared: 9/15/2012 10:30 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: — Time:
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 PEKIN MEMORIAL HOSPITAL for the cost reporting period beginning 05/01/2011 and ending 04/30/2012 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	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	34,979	56,305	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	182		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	34,979	56,487	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 9/15/2012 10:30 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 600 SOUTH 13TH STREET	PO Box:			1.00
2.00	City: PEKIN	State: IL	Zip Code: 61554-	County: TAZWELL	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PEKIN MEMORIAL HOSPITAL	140120	37900	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF						N	N	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF	PEKIN MEMORIAL SNF	145766	37900		10/01/1993	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	PEKIN HOME HEALTH	147057	37900		01/01/1966	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2011	04/30/2012	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.	Y	N	22.00
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.	1	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,036	504	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.	1		26.00
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140120	Period: From 05/01/2011 To 04/30/2012	Worksheet S-2 Part I Date/Time Prepared: 9/15/2012 10:30 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for 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			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 in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	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.				
64.00	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 9/15/2012 10:30 am

		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	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. (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	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 9/15/2012 10:30 am

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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	109.00

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 9/15/2012 10:30 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	905,341	0	0	118.01

		1.00	2.00	
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.	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.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H076	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: PROGRESSIVE HEALTH SYSTEMS	Contractor's Name: NATIONAL GOVERNMENT SERVICES, INC	Contractor's Number: 00131	141.00
142.00	Street: 600 SOUTH 13TH STREET	PO Box:		142.00
143.00	City: PEKIN	State: IL	Zip Code: 61554	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 9/15/2012 10:30 am

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	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	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 9/15/2012 10:30 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	07/13/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 9/15/2012 10:30 am

		Description	Part A Y/N	Part A Date		
		0	1.00	2.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N			21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	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.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			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.			Y		40.00
			1.00	2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.		BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		314-231-5544	KWELLEN@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part II Date/Time Prepared: 9/15/2012 10:30 am

		Part B					
		Y/N	Date				
		3.00	4.00				
	PS&R Data						
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	07/13/2012				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N					17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N					18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N					19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N					20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N					21.00
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		SENIOR MANAGING CONSULTANT				41.00
42.00	Enter the employer/company name of the cost report preparer.						42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.						43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 9/15/2012 10:30 am

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		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	90	32,940	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)		90	32,940	0.00		7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,928	0.00		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00					13.00
14.00	Total (see instructions)		98	35,868	0.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	27	9,882			19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		125				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: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 9/15/2012 10:30 am

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	7,086	1,396	12,757		1.00
2.00	HMO		1,606	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	7,086	1,396	12,757		7.00
8.00	INTENSIVE CARE UNIT	0	621	93	1,158		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	0		519	847		13.00
14.00	Total (see instructions)	0	7,707	2,008	14,762		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	2,390	0	2,950		19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	6,180	296	9,650		22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		338	1,908		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				151		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			67	91		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part I Date/Time Prepared: 9/15/2012 10:30 am

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	1,655	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	550.44	0.00	0	1,655	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00	15.54	0.00			19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00	9.34	0.00			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	575.32	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: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 9/15/2012 10:30 am

	Cost Center Description	Discharges			
		Title XIX	Total All Patients		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	638	3,497		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)	638	3,497		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF				16.00
17.00	SUBPROVIDER - IRF				17.00
18.00	SUBPROVIDER				18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part II Date/Time Prepared: 9/15/2012 10:30 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
		1.00	2.00	3.00	4.00	5.00	
	PART II - WAGE DATA						
	SALARIES						
1.00	Total salaries (see instructions)	200.00	28,034,071	0	28,034,071	1,196,655.48	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		1,877,478	0	1,877,478	20,841.63	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	7.01
8.00	Home office personnel		1,763,631	0	1,763,631	54,477.58	8.00
9.00	SNF	44.00	722,884	0	722,884	32,315.03	9.00
10.00	Excluded area salaries (see instructions)		558,592	0	558,592	21,099.46	10.00
	OTHER WAGES & RELATED COSTS						
11.00	Contract labor (see instructions)		2,160,306	0	2,160,306	39,014.45	11.00
12.00	Contract management and administrative services		0	0	0	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	13.00
14.00	Home office salaries & wage-related costs		1,467,687	0	1,467,687	45,489.96	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	15.00
16.00	Home office and Contract Physicians Part A - Administrative		0	0	0	0.00	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		6,757,584	0	6,757,584		17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25		0	0	0		18.00
19.00	Excluded areas		334,050	0	334,050		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		252,498	0	252,498		21.00
22.00	Physician Part A - Administrative		0	0	0		22.00
22.01	Physician Part A - Teaching		0	0	0		22.01
23.00	Physician Part B		0	0	0		23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0		24.00
25.00	Interns & residents (in an approved program)		0	0	0		25.00
	OVERHEAD COSTS - DIRECT SALARIES						
26.00	Employee Benefits	4.00	0	200,446	200,446	9,146.35	26.00
27.00	Administrative & General	5.00	4,665,407	-200,446	4,464,961	211,401.47	27.00
28.00	Administrative & General under contract (see inst.)		743,659	0	743,659	3,009.66	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	29.00
30.00	Operation of Plant	7.00	536,946	0	536,946	23,216.22	30.00
31.00	Laundry & Linen Service	8.00	140,733	0	140,733	12,116.18	31.00
32.00	Housekeeping	9.00	737,516	0	737,516	68,217.11	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	33.00
34.00	Dietary	10.00	623,769	-450,482	173,287	13,908.30	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	35.00
36.00	Cafeteria	11.00	0	450,482	450,482	36,157.56	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	927,775	0	927,775	56,447.35	38.00
39.00	Central Services and Supply	14.00	74,314	0	74,314	5,819.45	39.00
40.00	Pharmacy	15.00	770,531	0	770,531	22,453.74	40.00
41.00	Medical Records & Medical Records Library	16.00	635,110	0	635,110	37,273.57	41.00
42.00	Social Service	17.00	0	0	0	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part II | Date/Time Prepared: 9/15/2012 10:30 am

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART II - WAGE DATA			
	SALARIES			
1.00	Total salaries (see instructions)	23.43		1.00
2.00	Non-physician anesthetist Part A	0.00		2.00
3.00	Non-physician anesthetist Part B	90.08		3.00
4.00	Physician-Part A - Administrative	0.00		4.00
4.01	Physicians - Part A - Teaching	0.00		4.01
5.00	Physician-Part B	0.00		5.00
6.00	Non-physician-Part B	0.00		6.00
7.00	Interns & residents (in an approved program)	0.00		7.00
7.01	Contracted interns and residents (in an approved programs)	0.00		7.01
8.00	Home office personnel	32.37		8.00
9.00	SNF	22.37		9.00
10.00	Excluded area salaries (see instructions)	26.47		10.00
	OTHER WAGES & RELATED COSTS			
11.00	Contract labor (see instructions)	55.37		11.00
12.00	Contract management and administrative services	0.00		12.00
13.00	Contract labor: Physician-Part A - Administrative	0.00		13.00
14.00	Home office salaries & wage-related costs	32.26		14.00
15.00	Home office: Physician Part A - Administrative	0.00		15.00
16.00	Home office and Contract Physicians Part A - Administrative	0.00		16.00
	WAGE-RELATED COSTS			
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24			17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25			18.00
19.00	Excluded areas			19.00
20.00	Non-physician anesthetist Part A			20.00
21.00	Non-physician anesthetist Part B			21.00
22.00	Physician Part A - Administrative			22.00
22.01	Physician Part A - Teaching			22.01
23.00	Physician Part B			23.00
24.00	Wage-related costs (RHC/FQHC)			24.00
25.00	Interns & residents (in an approved program)			25.00
	OVERHEAD COSTS - DIRECT SALARIES			
26.00	Employee Benefits	21.92		26.00
27.00	Administrative & General	21.12		27.00
28.00	Administrative & General under contract (see inst.)	247.09		28.00
29.00	Maintenance & Repairs	0.00		29.00
30.00	Operation of Plant	23.13		30.00
31.00	Laundry & Linen Service	11.62		31.00
32.00	Housekeeping	10.81		32.00
33.00	Housekeeping under contract (see instructions)	0.00		33.00
34.00	Dietary	12.46		34.00
35.00	Dietary under contract (see instructions)	0.00		35.00
36.00	Cafeteria	12.46		36.00
37.00	Maintenance of Personnel	0.00		37.00
38.00	Nursing Administration	16.44		38.00
39.00	Central Services and Supply	12.77		39.00
40.00	Pharmacy	34.32		40.00
41.00	Medical Records & Medical Records Library	17.04		41.00
42.00	Social Service	0.00		42.00
43.00	Other General Service	0.00		43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part III Date/Time Prepared: 9/15/2012 10:30 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
		1.00	2.00	3.00	4.00	5.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)		25,136,621	0	25,136,621	1,124,345.93	1.00
2.00	Excluded area salaries (see instructions)		1,281,476	0	1,281,476	53,414.49	2.00
3.00	Subtotal salaries (line 1 minus line 2)		23,855,145	0	23,855,145	1,070,931.44	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,627,993	0	3,627,993	84,504.41	4.00
5.00	Subtotal wage-related costs (see inst.)		6,757,584	0	6,757,584	0.00	5.00
6.00	Total (sum of lines 3 thru 5)		34,240,722	0	34,240,722	1,155,435.85	6.00
7.00	Total overhead cost (see instructions)		9,855,760	0	9,855,760	499,166.96	7.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part III Date/Time Prepared: 9/15/2012 10:30 am

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	22.36		1.00
2.00	Excluded area salaries (see instructions)	23.99		2.00
3.00	Subtotal salaries (line 1 minus line 2)	22.28		3.00
4.00	Subtotal other wages & related costs (see inst.)	42.93		4.00
5.00	Subtotal wage-related costs (see inst.)	28.33		5.00
6.00	Total (sum of lines 3 thru 5)	29.63		6.00
7.00	Total overhead cost (see instructions)	19.74		7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part IV Date/Time Prepared: 9/15/2012 10:30 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost (see instructions)	1,221,896	3.00
4.00	Pension Service Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	142,780	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	35,646	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,336,531	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	24,770	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	549,534	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,987,586	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	25,472	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (see instructions)	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	19,917	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,344,132	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part V Date/Time Prepared: 9/15/2012 10:30 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	7,666,546	141,768	1.00
2.00	Hospital	7,359,475	141,768	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	32,979	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	274,092	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00		0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 140120 | Component CCN: 147057 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-4 | Date/Time Prepared: 9/15/2012 10:30 am

Home Health Agency I | PPS

		1.00	
0.00	County	TAZEWELL	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	1,825	0	45	1,870	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	429.00	18.00	91.00	538.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	1.99	0.00	1.99	3.00
4.00	Director(s) and Assistant Director(s)		1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		5.01	0.00	5.01	6.00
7.00	Nursing Supervisor		1.00	0.00	1.00	7.00
8.00	Physical Therapy Service		0.00	3.52	3.52	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.20	0.20	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.04	0.04	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.34	0.00	0.34	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		37900			20.00
20.01			99914			20.01

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,886	0	67	83	3,036	21.00
22.00	Skilled Nursing Visit Charges	501,117	0	11,658	14,382	527,157	22.00
23.00	Physical Therapy Visits	1,990	0	16	55	2,061	23.00
24.00	Physical Therapy Visit Charges	377,303	0	3,040	10,405	390,748	24.00
25.00	Occupational Therapy Visits	148	0	0	7	155	25.00
26.00	Occupational Therapy Visit Charges	28,367	0	0	1,344	29,711	26.00
27.00	Speech Pathology Visits	55	0	0	1	56	27.00
28.00	Speech Pathology Visit Charges	11,385	0	0	207	11,592	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	843	0	4	25	872	31.00
32.00	Home Health Aide Visit Charges	66,335	0	316	1,975	68,626	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,922	0	87	171	6,180	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	984,507	0	15,014	28,313	1,027,834	35.00
36.00	Total Number of Episodes (standard/non outlier)	357		30	13	400	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	11,255	0	139	210	11,604	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-7 | Date/Time Prepared: 9/15/2012 10:30 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	12	0	12	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	28	0	28	12.00
13.00		RUB	11	0	11	13.00
14.00		RUA	152	0	152	14.00
15.00		RVC	58	0	58	15.00
16.00		RVB	112	0	112	16.00
17.00		RVA	530	0	530	17.00
18.00		RHC	46	0	46	18.00
19.00		RHB	148	0	148	19.00
20.00		RHA	417	0	417	20.00
21.00		RMC	43	0	43	21.00
22.00		RMB	57	0	57	22.00
23.00		RMA	361	0	361	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	5	0	5	32.00
33.00		HC2	9	0	9	33.00
34.00		HC1	4	0	4	34.00
35.00		HB2	7	0	7	35.00
36.00		HB1	60	0	60	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	30	0	30	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	35	0	35	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	41	0	41	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	4	0	4	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	3	0	3	48.00
49.00		CC2	10	0	10	49.00
50.00		CC1	7	0	7	50.00
51.00		CB2	16	0	16	51.00
52.00		CB1	87	0	87	52.00
53.00		CA2	19	0	19	53.00
54.00		CA1	75	0	75	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-7 | Date/Time Prepared: 9/15/2012 10:30 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	2	0	2	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	1	0	1	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		2,390	0	2,390	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	37900	37900	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	722,884	38.59	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	213	0.01	Y	204.00
205.00	Training	0	0.00		205.00
206.00	CONTRACT LABOR	32,979	1.76	Y	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,873,250			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-10 | Date/Time Prepared: 9/15/2012 10:30 am

		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)	0.240015	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,616,495	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,396,490	5.00
6.00	Medicaid charges	34,671,601	6.00
7.00	Medicaid cost (line 1 times line 6)	8,321,704	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)	2,308,719	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	44,246	9.00
10.00	Stand-alone SCHIP charges	416,208	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	99,896	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	55,650	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)	2,364,369	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		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	6,660,076	0	6,660,076	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,598,518	0	1,598,518	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,598,518	0	1,598,518	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	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)	6,987,557	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	301,833	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	6,685,724	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,604,674	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	3,203,192	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,567,561	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A | Date/Time Prepared: 9/15/2012 10:30 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,285,905	1,285,905	1,040,577	2,326,482	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,325,148	2,325,148	42,487	2,367,635	2.00
3.00	00300	OTHER CAP RELATED COST		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	0	6,686,665	6,686,665	482,177	7,168,842	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,665,407	8,241,493	12,906,900	-1,237,961	11,668,939	5.00
7.00	00700	OPERATION OF PLANT	536,946	1,434,864	1,971,810	18,071	1,989,881	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	140,733	111,227	251,960	0	251,960	8.00
9.00	00900	HOUSEKEEPING	737,516	374,230	1,111,746	0	1,111,746	9.00
10.00	01000	DIETARY	623,769	887,314	1,511,083	-1,091,295	419,788	10.00
11.00	01100	CAFETERIA	0	0	0	1,091,295	1,091,295	11.00
13.00	01300	NURSING ADMINISTRATION	927,775	40,979	968,754	-182	968,572	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	74,314	256,634	330,948	-293,343	37,605	14.00
15.00	01500	PHARMACY	770,531	2,470,547	3,241,078	-2,162,153	1,078,925	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	635,110	112,345	747,455	-2,207	745,248	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,033,276	494,215	6,527,491	-1,062,521	5,464,970	30.00
31.00	03100	INTENSIVE CARE UNIT	1,197,503	33,358	1,230,861	18,995	1,249,856	31.00
43.00	04300	NURSERY	0	0	0	201,152	201,152	43.00
44.00	04400	SKILLED NURSING FACILITY	722,884	90,980	813,864	-16,909	796,955	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,109,874	4,216,752	6,326,626	-3,680,620	2,646,006	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	645,533	645,533	52.00
53.00	05300	ANESTHESIOLOGY	1,908,919	191,191	2,100,110	-102,232	1,997,878	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,209,269	551,967	1,761,236	121,084	1,882,320	54.00
56.00	05600	RADIOISOTOPE	140,366	372,489	512,855	-1,744	511,111	56.00
57.00	05700	CT SCAN	248,962	308,378	557,340	15,337	572,677	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	141,516	66,219	207,735	-39,599	168,136	58.00
59.00	05900	CARDIAC CATHETERIZATION	291,684	401,077	692,761	-312,982	379,779	59.00
60.00	06000	LABORATORY	1,095,516	1,276,015	2,371,531	-63,025	2,308,506	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	548,632	548,632	32,690	581,322	63.00
65.00	06500	RESPIRATORY THERAPY	408,396	84,371	492,767	-43,350	449,417	65.00
66.00	06600	PHYSICAL THERAPY	0	865,593	865,593	1,168	866,761	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	259,270	259,270	-810	258,460	67.00
68.00	06800	SPEECH PATHOLOGY	0	153,195	153,195	2,893	156,088	68.00
69.00	06900	ELECTROCARDIOLOGY	457,388	306,308	763,696	5,762	769,458	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,844,328	3,844,328	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	1,574,413	1,574,413	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,191,477	2,191,477	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	0	163,420	163,420	-61	163,359	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	162,452	116,851	279,303	-8,645	270,658	90.00
91.00	09100	EMERGENCY	2,235,373	850,823	3,086,196	-230,151	2,856,045	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	542,414	360,660	903,074	-14,875	888,199	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		964,774	964,774	-964,774	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,017,893	36,903,889	64,921,782	0	64,921,782	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	16,178	831	17,009	0	17,009	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	28,034,071	36,904,720	64,938,791	0	64,938,791	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A | Date/Time Prepared: 9/15/2012 10:30 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-44,344	2,282,138		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-120,484	2,247,151		2.00
3.00	00300	OTHER CAP RELATED COST	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	-1,321,778	5,847,064		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,049,559	8,619,380		5.00
7.00	00700	OPERATION OF PLANT	0	1,989,881		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-2,439	249,521		8.00
9.00	00900	HOUSEKEEPING	0	1,111,746		9.00
10.00	01000	DIETARY	0	419,788		10.00
11.00	01100	CAFETERIA	-543,402	547,893		11.00
13.00	01300	NURSING ADMINISTRATION	-9,671	958,901		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-7,920	29,685		14.00
15.00	01500	PHARMACY	-300	1,078,625		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-32,521	712,727		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-480	5,464,490		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,249,856		31.00
43.00	04300	NURSERY	-524	200,628		43.00
44.00	04400	SKILLED NURSING FACILITY	-15,010	781,945		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,646,006		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	645,533		52.00
53.00	05300	ANESTHESIOLOGY	-1,877,478	120,400		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-9,125	1,873,195		54.00
56.00	05600	RADIOISOTOPE	0	511,111		56.00
57.00	05700	CT SCAN	0	572,677		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	168,136		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	379,779		59.00
60.00	06000	LABORATORY	-74,724	2,233,782		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	581,322		63.00
65.00	06500	RESPIRATORY THERAPY	0	449,417		65.00
66.00	06600	PHYSICAL THERAPY	-3,160	863,601		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	258,460		67.00
68.00	06800	SPEECH PATHOLOGY	0	156,088		68.00
69.00	06900	ELECTROCARDIOLOGY	-295,520	473,938		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,844,328		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	1,574,413		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,191,477		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	SLEEP LAB	-162,950	409		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-96,380	174,278		90.00
91.00	09100	EMERGENCY	-503,178	2,352,867		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	888,199		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,170,947	56,750,835		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	17,009		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	RENTED SPACE	0	0		194.01
194.02	07952	FOUNDATION	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-8,170,947	56,767,844		200.00

RECLASSIFICATIONS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-6 | Date/Time Prepared: 9/15/2012 10:30 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	450,482	640,813		1.00
	TOTALS		450,482	640,813		
	B - TO RECLASS BLOOD SALARIES FROM LAB					
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	45,440	0		1.00
	TOTALS		45,440	0		
	C - TO RECLASS LDR EXPENSES					
1.00	NURSERY	43.00	191,276	6,588		1.00
2.00	LABOR ROOM & DELIVERY ROOM	52.00	613,838	21,142		2.00
	TOTALS		805,114	27,730		
	D - TO RECLASS CLINICAL ENGINEERING EXP					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	22,749		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	11,827		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	24,169		3.00
4.00	NURSERY	43.00	0	3,288		4.00
5.00	SKILLED NURSING FACILITY	44.00	0	1,682		5.00
6.00	OPERATING ROOM	50.00	0	96,304		6.00
7.00	LABOR ROOM & DELIVERY ROOM	52.00	0	10,553		7.00
8.00	ANESTHESIOLOGY	53.00	0	32,101		8.00
9.00	RADIOLOGY - DIAGNOSTIC	54.00	0	168,781		9.00
10.00	RADIOISOTOPE	56.00	0	4,441		10.00
11.00	CT SCAN	57.00	0	91,936		11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	73,176		12.00
13.00	LABORATORY	60.00	0	39,208		13.00
14.00	RESPIRATORY THERAPY	65.00	0	19,603		14.00
15.00	PHYSICAL THERAPY	66.00	0	2,580		15.00
16.00	SPEECH PATHOLOGY	68.00	0	2,893		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	11,930		17.00
18.00	CLINIC	90.00	0	6,925		18.00
19.00	EMERGENCY	91.00	0	15,347		19.00
	TOTALS		0	639,493		
	E - TO RECLASS SUPPLY COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,844,328		1.00
2.00	IMP. DEV CHARGED TO PATIENT	72.00	0	1,574,413		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
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
	TOTALS		0	5,418,741		
	F - TO RECLASS BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,191,477		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
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00

RECLASSIFICATIONS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-6 | Date/Time Prepared: 9/15/2012 10:30 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
16.00		0.00	0	0	16.00
	TOTALS		0	2,191,477	
	G - TO RECLASS TELEPHONE EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00		6,934	1.00
2.00	SKILLED NURSING FACILITY	44.00	0	8	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	6,942	
	H - TO RECLASS HUMAN RESOURCES				
1.00	EMPLOYEE BENEFITS	4.00	200,446	281,731	1.00
	TOTALS		200,446	281,731	
	I - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	964,774	1.00
	TOTALS		0	964,774	
	J - TO RECLASS PROPERTY INSURANCE				
1.00	OTHER CAP RELATED COST	3.00	0	118,290	1.00
	TOTALS		0	118,290	
	K - TO RECLASS MRI LEASE EXPENSE				
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	4,935	1.00
	TOTALS		0	4,935	
	L - TO RECLASS MRI BUILDING UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	18,071	1.00
	TOTALS		0	18,071	
500.00	Grand Total: Increases		1,501,482	10,312,997	500.00

RECLASSIFICATIONS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-6 | Date/Time Prepared: 9/15/2012 10:30 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	450,482	640,813	0		1.00
	TOTALS		450,482	640,813			
	B - TO RECLASS BLOOD SALARIES FROM LAB						
1.00	LABORATORY	60.00	45,440	0	0		1.00
	TOTALS		45,440	0			
	C - TO RECLASS LDR EXPENSES						
1.00	ADULTS & PEDIATRICS	30.00	805,114	27,730	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		805,114	27,730			
	D - TO RECLASS CLINICAL ENGINEERING EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	639,493	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
	TOTALS		0	639,493			
	E - TO RECLASS SUPPLY COSTS						
1.00	NURSING ADMINISTRATION	13.00	0	182	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	299,525	0		2.00
3.00	PHARMACY	15.00	0	74,550	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	228,443	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	5,170	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	16,908	0		6.00
7.00	OPERATING ROOM	50.00	0	3,771,784	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	131,375	0		8.00
9.00	RADIOLOGY - DIAGNOSTIC	54.00	0	43,230	0		9.00
10.00	RADIOISOTOPE	56.00	0	5,830	0		10.00
11.00	CT SCAN	57.00	0	41,305	0		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	23,918	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	382,095	0		13.00
14.00	LABORATORY	60.00	0	56,793	0		14.00
15.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	0	1,061	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	62,844	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	1,412	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	810	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	6,165	0		19.00
20.00	SLEEP LAB	76.00	0	61	0		20.00
21.00	CLINIC	90.00	0	15,555	0		21.00
22.00	EMERGENCY	91.00	0	234,850	0		22.00
23.00	HOME HEALTH AGENCY	101.00	0	14,875	0		23.00
	TOTALS		0	5,418,741			
	F - TO RECLASS BILLABLE DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	16,567	0		1.00
2.00	PHARMACY	15.00	0	2,087,603	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	13,061	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	4	0		4.00
5.00	SKILLED NURSING FACILITY	44.00	0	1,691	0		5.00
6.00	OPERATING ROOM	50.00	0	5,140	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	2,958	0		7.00
8.00	RADIOLOGY - DIAGNOSTIC	54.00	0	2,277	0		8.00
9.00	RADIOISOTOPE	56.00	0	355	0		9.00
10.00	CT SCAN	57.00	0	35,294	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	4,063	0		11.00
12.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	0	11,689	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	109	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	3	0		14.00

RECLASSIFICATIONS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-6 | Date/Time Prepared: 9/15/2012 10:30 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
15.00	CLINIC	90.00	0	15	0		15.00
16.00	EMERGENCY	91.00	0	10,648	0		16.00
	TOTALS		0	2,191,477			
	G - TO RECLASS TELEPHONE EXPENSE						
1.00	MEDICAL RECORDS & LIBRARY	16.00		2,207	0		1.00
2.00	RADIOLOGY - DIAGNOSTIC	54.00		2,190	0		2.00
3.00		58.00		2,545	0		3.00
	TOTALS		0	6,942			
	H - TO RECLASS HUMAN RESOURCES						
1.00	ADMINISTRATIVE & GENERAL	5.00	200,446	281,731	0		1.00
	TOTALS		200,446	281,731			
	I - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	964,774	11		1.00
	TOTALS		0	964,774			
	J - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	118,290	0		1.00
	TOTALS		0	118,290			
	K - TO RECLASS MRI LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,935	0		1.00
	TOTALS		0	4,935			
	L - TO RECLASS MRI BUILDING UTILITIES						
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	18,071	0		1.00
	TOTALS		0	18,071			
500.00	Grand Total: Decreases		1,501,482	10,312,997			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 9/15/2012 10:30 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,449,581	0	0	0	0	1.00
2.00	Land Improvements	1,801,151	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,554,361	0	0	0	0	3.00
4.00	Building Improvements	16,676,915	871,663	0	871,663	1,950	4.00
5.00	Fixed Equipment	14,068,494	804,917	0	804,917	108,150	5.00
6.00	Movable Equipment	24,316,937	2,589,531	0	2,589,531	97,183	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	69,867,439	4,266,111	0	4,266,111	207,283	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	69,867,439	4,266,111	0	4,266,111	207,283	10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,285,905	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,325,148	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,611,053	0	0	0	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	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	47,116,982	0	47,116,982	0.640821	75,803	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	26,809,285	400,341	26,408,944	0.359179	42,487	2.00
3.00	Total (sum of lines 1-2)	73,926,267	400,341	73,525,926	1.000000	118,290	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 9/15/2012 10:30 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,449,581	0				1.00
2.00	Land Improvements	1,801,151	0				2.00
3.00	Buildings and Fixtures	11,554,361	0				3.00
4.00	Building Improvements	17,546,628	0				4.00
5.00	Fixed Equipment	14,765,261	0				5.00
6.00	Movable Equipment	26,809,285	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	73,926,267	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	73,926,267	0				10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,285,905				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,325,148				2.00
3.00	Total (sum of lines 1-2)	0	3,611,053				3.00

		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
	Cost Center Description	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	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	75,803	1,355,385	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	42,487	2,204,664	0	2.00
3.00	Total (sum of lines 1-2)	0	0	118,290	3,560,049	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 9/15/2012 10:30 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	850,950	75,803	0	0	2,282,138	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	42,487	0	0	2,247,151	2.00
3.00	Total (sum of lines 1-2)	850,950	118,290	0	0	4,529,289	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-8 | Date/Time Prepared: 9/15/2012 10:30 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-113,824	CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,105,956			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-2,520,479			12.00
13.00	Laundry and linen service	B	-2,439	LAUNDRY & LINEN SERVICE	8.00	13.00
14.00	Cafeteria-employees and guests	B	-373,643	CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-7,920	CENTRAL SERVICES & SUPPLY	14.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts	B	-32,521	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	MEALS ON WHEELS AND CATERING	B	-169,759	CAFETERIA	11.00	33.00
33.01	WELLNESS CENTER AND AEROBICS CLASSES	B	-19,572	ELECTROCARDIOLOGY	69.00	33.01
33.02	PHYSICAL THERAPY OTHER INCOME	B	-3,160	PHYSICAL THERAPY	66.00	33.02
33.03	EDUCATION REVENUE	B	-9,671	NURSING ADMINISTRATION	13.00	33.03
33.04	SICKBAY REVENUE	B	-480	ADULTS & PEDIATRICS	30.00	33.04
33.05	RADIOLOGY TRANSCRIPT REVENUE	B	-9,125	RADIOLOGY - DIAGNOSTIC	54.00	33.05
33.06	NURSERY OTHER INCOME	B	-524	NURSERY	43.00	33.06
33.07	CORONER AUTOPSY FEES	B	-7,224	LABORATORY	60.00	33.07
33.08	CASH ADJUSMENTS	B	337	ADMINISTRATIVE & GENERAL	5.00	33.08
33.09	MISCELLANEOUS OTHER INCOME	B	-59,412	ADMINISTRATIVE & GENERAL	5.00	33.09
33.10	DEPRECIATION LAPSING SCHEDULES	A	69,480	CAP REL COSTS-BLDG & FIXT	1.00	33.10
33.11	ADVERSTISING SALARY EXPENSE	A	-153,375	ADMINISTRATIVE & GENERAL	5.00	33.11
33.12	ADVERTISING EXPENSE	A	-577,269	ADMINISTRATIVE & GENERAL	5.00	33.12
33.13	ADVERTISING BENEFITS	A	-30,911	EMPLOYEE BENEFITS	4.00	33.13
33.14	CRNA SALARIES	A	-1,877,478	ANESTHESIOLOGY	53.00	33.14
33.15	CRNA EMPLOYEE BENEFITS	A	-150,644	EMPLOYEE BENEFITS	4.00	33.15
33.16	BOOK FAIR PROCEEDS	B	-4,534	ADMINISTRATIVE & GENERAL	5.00	33.16
33.17	FEDERAL EXCISE TAX	A	-300	PHARMACY	15.00	33.17
33.18	IDPA BED TAX	A	-15,010	SKILLED NURSING FACILITY	44.00	33.18
33.19	SELF INSURANCE EXPENSE	A	-1,063,424	EMPLOYEE BENEFITS	4.00	33.19
33.20	HEALTHLINK FEES	A	67,890	ADMINISTRATIVE & GENERAL	5.00	33.20

ADJUSTMENTS TO EXPENSES | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-8 | Date/Time Prepared: 9/15/2012 10:30 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,170,947			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-8 | Date/Time Prepared: 9/15/2012 10:30 am

	Cost Center Description	Wkst. A-7 Ref. 5.00					
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	11					1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0					2.00
3.00	Investment income - other (chapter 2)	0					3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0					4.00
5.00	Refunds and rebates of expenses (chapter 8)	0					5.00
6.00	Rental of provider space by suppliers (chapter 8)	0					6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0					7.00
8.00	Television and radio service (chapter 21)	0					8.00
9.00	Parking lot (chapter 21)	0					9.00
10.00	Provider-based physician adjustment	0					10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0					11.00
12.00	Related organization transactions (chapter 10)	0					12.00
13.00	Laundry and linen service	0					13.00
14.00	Cafeteria-employees and guests	0					14.00
15.00	Rental of quarters to employee and others	0					15.00
16.00	Sale of medical and surgical supplies to other than patients	0					16.00
17.00	Sale of drugs to other than patients	0					17.00
18.00	Sale of medical records and abstracts	0					18.00
19.00	Nursing school (tuition, fees, books, etc.)	0					19.00
20.00	Vending machines	0					20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0					21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0					22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)						23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)						24.00
25.00	Utilization review - physicians' compensation (chapter 21)						25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0					26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0					27.00
28.00	Non-physician Anesthetist						28.00
29.00	Physicians' assistant	0					29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)						30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)						31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0					32.00
33.00	MEALS ON WHEELS AND CATERING	0					33.00
33.01	WELLNESS CENTER AND AEROBICS CLASSES	0					33.01
33.02	PHYSICAL THERAPY OTHER INCOME	0					33.02
33.03	EDUCATION REVENUE	0					33.03
33.04	SICKBAY REVENUE	0					33.04
33.05	RADIOLOGY TRANSCRIPT REVENUE	0					33.05
33.06	NURSERY OTHER INCOME	0					33.06
33.07	CORONER AUTOPSY FEES	0					33.07
33.08	CASH ADJUSMENTS	0					33.08
33.09	MISCELLANEOUS OTHER INCOME	0					33.09
33.10	DEPRECIATION LAPSING SCHEDULES	9					33.10
33.11	ADVERSTISING SALARY EXPENSE	0					33.11
33.12	ADVERTISING EXPENSE	0					33.12
33.13	ADVERTISING BENEFITS	0					33.13
33.14	CRNA SALARIES	0					33.14
33.15	CRNA EMPLOYEE BENEFITS	0					33.15
33.16	BOOK FAIR PROCEEDS	0					33.16
33.17	FEDERAL EXCISE TAX	0					33.17
33.18	IDPA BED TAX	0					33.18
33.19	SELF INSURANCE EXPENSE	0					33.19
33.20	HEALTHLINK FEES	0					33.20
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: 140120	Period: From 05/01/2011 To 04/30/2012	Worksheet A-8-1 Date/Time Prepared: 9/15/2012 10:30 am

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL COST MME	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE/FINANCE/IS	2.00
3.00		5.00	ADMINISTRATIVE & GENERAL	PROVIDER TAX HOSPITAL	3.00
4.00		4.00	EMPLOYEE BENEFITS	HUMAN RESOURCES	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		B		100.00		6.00
7.00				0.00		7.00
8.00				0.00		8.00
9.00				0.00		9.00
10.00				0.00		10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-8-1 | Date/Time Prepared: 9/15/2012 10:30 am

		Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
		4.00	5.00	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		686,750	807,234	-120,484	9		1.00
2.00		3,383,150	4,162,277	-779,127	0		2.00
3.00		0	1,544,069	-1,544,069	0		3.00
4.00		405,378	482,177	-76,799	0		4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	4,475,278	6,995,757	-2,520,479			5.00

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

		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				
6.00		PROGRESSIVE HLT	0.00	HEALTH CARE MGT	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

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.

(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: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 9/15/2012 10:30 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		76.00	SLEEP LAB	162,950	162,950	1.00
2.00		91.00	EMERGENCY	503,178	503,178	2.00
3.00		90.00	CLINIC	96,380	96,380	3.00
4.00		60.00	LABORATORY	67,500	67,500	4.00
5.00		69.00	ELECTROCARDIOLOGY	275,948	275,948	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				1,105,956	1,105,956	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 9/15/2012 10:30 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 9/15/2012 10:30 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 9/15/2012 10:30 am

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	162,950		1.00
2.00		0	503,178		2.00
3.00		0	96,380		3.00
4.00		0	67,500		4.00
5.00		0	275,948		5.00
6.00		0	0		6.00
7.00		0	0		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	1,105,956		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B Part I Date/Time Prepared: 9/15/2012 10:30 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,282,138	2,282,138				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,247,151		2,247,151			2.00
4.00	00400	EMPLOYEE BENEFITS	5,847,064	11,109	684	5,858,857		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,619,380	633,475	691,078	979,002	10,922,935	5.00
7.00	00700	OPERATION OF PLANT	1,989,881	200,242	28,640	121,921	2,340,684	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	249,521	28,182	12,559	31,955	322,217	8.00
9.00	00900	HOUSEKEEPING	1,111,746	2,223	4,875	167,463	1,286,307	9.00
10.00	01000	DIETARY	419,788	49,334	17,345	39,347	525,814	10.00
11.00	01100	CAFETERIA	547,893	15,007	0	102,288	665,188	11.00
13.00	01300	NURSING ADMINISTRATION	958,901	31,780	67,397	210,663	1,268,741	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	29,685	39,051	68,700	16,874	154,310	14.00
15.00	01500	PHARMACY	1,078,625	12,769	14,703	174,959	1,281,056	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	712,727	31,284	22,921	144,210	911,142	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,464,490	268,632	62,591	1,187,124	6,982,837	30.00
31.00	03100	INTENSIVE CARE UNIT	1,249,856	29,940	7,725	271,909	1,559,430	31.00
43.00	04300	NURSERY	200,628	7,774	8,961	43,432	260,795	43.00
44.00	04400	SKILLED NURSING FACILITY	781,945	74,985	10,980	164,140	1,032,050	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,646,006	153,853	329,224	479,074	3,608,157	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	645,533	25,238	28,755	139,380	838,906	52.00
53.00	05300	ANESTHESIOLOGY	120,400	2,621	73,168	7,139	203,328	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,873,195	117,002	435,787	274,580	2,700,564	54.00
56.00	05600	RADIOISOTOPE	511,111	6,572	45,623	31,872	595,178	56.00
57.00	05700	CT SCAN	572,677	18,846	4,014	56,530	652,067	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	168,136	15,263	51,444	32,133	266,976	58.00
59.00	05900	CARDIAC CATHETERIZATION	379,779	5,746	29,459	66,231	481,215	59.00
60.00	06000	LABORATORY	2,233,782	41,244	92,484	238,433	2,605,943	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	581,322	0	919	10,318	592,559	63.00
65.00	06500	RESPIRATORY THERAPY	449,417	11,462	24,014	92,732	577,625	65.00
66.00	06600	PHYSICAL THERAPY	863,601	29,669	2,324	0	895,594	66.00
67.00	06700	OCCUPATIONAL THERAPY	258,460	5,836	19	0	264,315	67.00
68.00	06800	SPEECH PATHOLOGY	156,088	13,663	0	0	169,751	68.00
69.00	06900	ELECTROCARDIOLOGY	473,938	33,275	91,649	103,856	702,718	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,844,328	0	0	0	3,844,328	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	1,574,413	0	0	0	1,574,413	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,191,477	0	0	0	2,191,477	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	409	5,558	0	0	5,967	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	174,278	15,180	2,181	36,887	228,526	90.00
91.00	09100	EMERGENCY	2,352,867	106,832	14,595	507,570	2,981,864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	888,199	13,986	414	123,162	1,025,761	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	56,750,835	2,057,633	2,245,232	5,855,184	56,520,738	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	17,009	46,172	1,657	3,673	68,511	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	141,437	262	0	141,699	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	0	33,170	0	0	33,170	194.01
194.02	07952	FOUNDATION	0	3,726	0	0	3,726	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	56,767,844	2,282,138	2,247,151	5,858,857	56,767,844	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B Part I Date/Time Prepared: 9/15/2012 10:30 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,922,935					5.00
7.00	00700	OPERATION OF PLANT	557,687	2,898,371				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	76,771	56,830	455,818			8.00
9.00	00900	HOUSEKEEPING	306,473	4,483	3,708	1,600,971		9.00
10.00	01000	DIETARY	125,279	99,483	279	56,139	806,994	10.00
11.00	01100	CAFETERIA	158,486	30,263	0	17,078	0	11.00
13.00	01300	NURSING ADMINISTRATION	302,288	64,085	0	36,164	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	36,766	78,747	1,424	44,437	0	14.00
15.00	01500	PHARMACY	305,222	25,749	0	14,530	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	217,087	63,085	0	35,600	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,663,735	541,702	130,890	305,686	648,462	30.00
31.00	03100	INTENSIVE CARE UNIT	371,547	60,374	66,367	34,070	57,773	31.00
43.00	04300	NURSERY	62,136	15,677	7,218	8,846	0	43.00
44.00	04400	SKILLED NURSING FACILITY	245,894	151,208	49,677	85,328	100,759	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	859,672	310,247	56,206	175,075	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	199,876	50,892	23,163	28,719	0	52.00
53.00	05300	ANESTHESIOLOGY	48,445	5,286	0	2,983	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	643,431	235,938	31,508	133,141	0	54.00
56.00	05600	RADIOISOTOPE	141,806	13,253	0	7,479	0	56.00
57.00	05700	CT SCAN	155,360	38,003	0	21,445	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	63,609	30,778	2,190	17,368	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	114,653	11,587	0	6,539	0	59.00
60.00	06000	LABORATORY	620,887	83,170	99	46,933	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	141,182	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	137,624	23,114	0	13,043	0	65.00
66.00	06600	PHYSICAL THERAPY	213,382	59,829	10,358	33,762	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,975	11,769	0	6,641	0	67.00
68.00	06800	SPEECH PATHOLOGY	40,445	27,552	0	15,548	0	68.00
69.00	06900	ELECTROCARDIOLOGY	167,428	67,099	788	37,865	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	915,942	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	375,116	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	522,137	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	1,422	11,208	740	6,325	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	54,448	30,611	0	17,274	0	90.00
91.00	09100	EMERGENCY	710,453	215,430	57,749	121,568	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	244,396	28,203	0	15,915	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,864,060	2,445,655	442,364	1,345,501	806,994	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	16,323	93,106	0	52,540	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	33,761	285,210	13,319	160,946	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	7,903	66,887	135	37,745	0	194.01
194.02	07952	FOUNDATION	888	7,513	0	4,239	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	10,922,935	2,898,371	455,818	1,600,971	806,994	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B Part I | Date/Time Prepared: 9/15/2012 10:30 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	871,015					11.00
13.00	01300	NURSING ADMINISTRATION	59,778	1,731,056				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,167	0	321,851			14.00
15.00	01500	PHARMACY	23,788	0	435	1,650,780		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	39,470	0	697	0	1,267,081	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	227,860	1,295,899	3,599	1,469	742,957	30.00
31.00	03100	INTENSIVE CARE UNIT	43,259	101,698	507	93	36,106	31.00
43.00	04300	NURSERY	7,753	74,385	110	24	54,396	43.00
44.00	04400	SKILLED NURSING FACILITY	34,228	259,074	477	0	16,870	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	86,055	0	4,366	0	267,205	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	24,889	0	353	77	0	52.00
53.00	05300	ANESTHESIOLOGY	24,273	0	466	11,711	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	58,060	0	1,425	1,530	0	54.00
56.00	05600	RADIOISOTOPE	4,251	0	10	425	0	56.00
57.00	05700	CT SCAN	9,053	0	76	159	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,621	0	257	5,076	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,427	0	103	0	0	59.00
60.00	06000	LABORATORY	50,616	0	1,213	96	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	2,181	0	7	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	19,779	0	356	59	102,208	65.00
66.00	06600	PHYSICAL THERAPY	0	0	325	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	30	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	19,779	0	384	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	214,152	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	87,704	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,628,572	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	0	0	5	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,828	0	261	0	0	90.00
91.00	09100	EMERGENCY	83,566	0	4,308	942	47,339	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	20,572	0	185	547	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	869,253	1,731,056	321,812	1,650,780	1,267,081	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,762	0	39	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	871,015	1,731,056	321,851	1,650,780	1,267,081	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B Part I | Date/Time Prepared: 9/15/2012 10:30 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	12,545,096	0	12,545,096		30.00
31.00	03100	INTENSIVE CARE UNIT	2,331,224	0	2,331,224		31.00
43.00	04300	NURSERY	491,340	0	491,340		43.00
44.00	04400	SKILLED NURSING FACILITY	1,975,565	0	1,975,565		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,366,983	0	5,366,983		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	1,166,875	0	1,166,875		52.00
53.00	05300	ANESTHESIOLOGY	296,492	0	296,492		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	3,805,597	0	3,805,597		54.00
56.00	05600	RADIOISOTOPE	762,402	0	762,402		56.00
57.00	05700	CT SCAN	876,163	0	876,163		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	393,875	0	393,875		58.00
59.00	05900	CARDIAC CATHETERIZATION	623,524	0	623,524		59.00
60.00	06000	LABORATORY	3,408,957	0	3,408,957		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	735,929	0	735,929		63.00
65.00	06500	RESPIRATORY THERAPY	873,808	0	873,808		65.00
66.00	06600	PHYSICAL THERAPY	1,213,250	0	1,213,250		66.00
67.00	06700	OCCUPATIONAL THERAPY	345,730	0	345,730		67.00
68.00	06800	SPEECH PATHOLOGY	253,297	0	253,297		68.00
69.00	06900	ELECTROCARDIOLOGY	996,061	0	996,061		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,974,422	0	4,974,422		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	2,037,233	0	2,037,233		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,342,186	0	4,342,186		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	SLEEP LAB	25,667	0	25,667		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	337,948	0	337,948		90.00
91.00	09100	EMERGENCY	4,223,219	0	4,223,219		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,335,579	0	1,335,579		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,738,422	0	55,738,422		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	232,281	0	232,281		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	634,935	0	634,935		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	RENTED SPACE	145,840	0	145,840		194.01
194.02	07952	FOUNDATION	16,366	0	16,366		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	56,767,844	0	56,767,844		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B Part II | Date/Time Prepared: 9/15/2012 10:30 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	11,109	684	11,793	11,793	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	32,268	633,475	691,078	1,356,821	1,970	5.00
7.00	00700	OPERATION OF PLANT	13,564	200,242	28,640	242,446	245	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	28,182	12,559	40,741	64	8.00
9.00	00900	HOUSEKEEPING	-38	2,223	4,875	7,060	337	9.00
10.00	01000	DIETARY	0	49,334	17,345	66,679	79	10.00
11.00	01100	CAFETERIA	0	15,007	0	15,007	206	11.00
13.00	01300	NURSING ADMINISTRATION	0	31,780	67,397	99,177	424	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,934	39,051	68,700	115,685	34	14.00
15.00	01500	PHARMACY	206,972	12,769	14,703	234,444	352	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,284	22,921	54,205	290	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,294	268,632	62,591	356,517	2,392	30.00
31.00	03100	INTENSIVE CARE UNIT	8,225	29,940	7,725	45,890	547	31.00
43.00	04300	NURSERY	0	7,774	8,961	16,735	87	43.00
44.00	04400	SKILLED NURSING FACILITY	1,815	74,985	10,980	87,780	330	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,364	153,853	329,224	495,441	964	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	25,238	28,755	53,993	281	52.00
53.00	05300	ANESTHESIOLOGY	0	2,621	73,168	75,789	14	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	5,942	117,002	435,787	558,731	553	54.00
56.00	05600	RADIOISOTOPE	0	6,572	45,623	52,195	64	56.00
57.00	05700	CT SCAN	0	18,846	4,014	22,860	114	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,935	15,263	51,444	71,642	65	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,746	29,459	35,205	133	59.00
60.00	06000	LABORATORY	0	41,244	92,484	133,728	480	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	919	919	21	63.00
65.00	06500	RESPIRATORY THERAPY	1,375	11,462	24,014	36,851	187	65.00
66.00	06600	PHYSICAL THERAPY	0	29,669	2,324	31,993	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,836	19	5,855	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,663	0	13,663	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	33,275	91,649	124,924	209	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	0	5,558	0	5,558	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	15,180	2,181	17,361	74	90.00
91.00	09100	EMERGENCY	0	106,832	14,595	121,427	1,022	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	13,986	414	14,400	248	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	320,650	2,057,633	2,245,232	4,623,515	11,786	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	46,172	1,657	47,829	7	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	141,437	262	141,699	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	0	33,170	0	33,170	0	194.01
194.02	07952	FOUNDATION	0	3,726	0	3,726	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	320,650	2,282,138	2,247,151	4,849,939	11,793	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B Part II | Date/Time Prepared: 9/15/2012 10:30 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,358,791					5.00
7.00	00700	OPERATION OF PLANT	69,376	312,067				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,550	6,119	56,474			8.00
9.00	00900	HOUSEKEEPING	38,125	483	459	46,464		9.00
10.00	01000	DIETARY	15,585	10,711	35	1,629	94,718	10.00
11.00	01100	CAFETERIA	19,716	3,258	0	496	0	11.00
13.00	01300	NURSING ADMINISTRATION	37,604	6,900	0	1,050	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,574	8,479	176	1,290	0	14.00
15.00	01500	PHARMACY	37,969	2,772	0	422	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,005	6,792	0	1,033	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	206,957	58,324	16,216	8,871	76,111	30.00
31.00	03100	INTENSIVE CARE UNIT	46,220	6,500	8,223	989	6,781	31.00
43.00	04300	NURSERY	7,730	1,688	894	257	0	43.00
44.00	04400	SKILLED NURSING FACILITY	30,589	16,281	6,155	2,476	11,826	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	106,942	33,404	6,964	5,081	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	24,864	5,480	2,870	833	0	52.00
53.00	05300	ANESTHESIOLOGY	6,026	569	0	87	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	80,042	25,403	3,904	3,864	0	54.00
56.00	05600	RADIOISOTOPE	17,640	1,427	0	217	0	56.00
57.00	05700	CT SCAN	19,327	4,092	0	622	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,913	3,314	271	504	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	14,263	1,248	0	190	0	59.00
60.00	06000	LABORATORY	77,238	8,955	12	1,362	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	17,563	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	17,120	2,489	0	379	0	65.00
66.00	06600	PHYSICAL THERAPY	26,545	6,442	1,283	980	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,834	1,267	0	193	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,031	2,966	0	451	0	68.00
69.00	06900	ELECTROCARDIOLOGY	20,828	7,225	98	1,099	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	113,942	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	46,664	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,953	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	177	1,207	92	184	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,773	3,296	0	501	0	90.00
91.00	09100	EMERGENCY	88,379	23,195	7,155	3,528	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	30,403	3,037	0	462	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,351,467	263,323	54,807	39,050	94,718	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,031	10,025	0	1,525	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,200	30,708	1,650	4,671	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	983	7,202	17	1,095	0	194.01
194.02	07952	FOUNDATION	110	809	0	123	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,358,791	312,067	56,474	46,464	94,718	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B Part II | Date/Time Prepared: 9/15/2012 10:30 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	38,683					11.00
13.00	01300	NURSING ADMINISTRATION	2,655	147,810				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	274	0	130,512			14.00
15.00	01500	PHARMACY	1,056	0	176	277,191		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,753	0	283	0	91,361	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,121	110,652	1,460	247	53,571	30.00
31.00	03100	INTENSIVE CARE UNIT	1,921	8,684	206	16	2,603	31.00
43.00	04300	NURSERY	344	6,352	45	4	3,922	43.00
44.00	04400	SKILLED NURSING FACILITY	1,520	22,122	194	0	1,216	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,822	0	1,770	0	19,266	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	1,105	0	143	13	0	52.00
53.00	05300	ANESTHESIOLOGY	1,078	0	189	1,966	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,579	0	578	257	0	54.00
56.00	05600	RADIOISOTOPE	189	0	4	71	0	56.00
57.00	05700	CT SCAN	402	0	31	27	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	338	0	104	852	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	419	0	42	0	0	59.00
60.00	06000	LABORATORY	2,248	0	492	16	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	97	0	3	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	878	0	144	10	7,370	65.00
66.00	06600	PHYSICAL THERAPY	0	0	132	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	12	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	878	0	156	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	86,838	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	35,564	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	273,462	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	0	0	2	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	303	0	106	0	0	90.00
91.00	09100	EMERGENCY	3,711	0	1,747	158	3,413	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	914	0	75	92	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	38,605	147,810	130,496	277,191	91,361	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	78	0	16	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	38,683	147,810	130,512	277,191	91,361	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B Part II | Date/Time Prepared: 9/15/2012 10:30 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	901,439	0	901,439		30.00
31.00	03100	INTENSIVE CARE UNIT	128,580	0	128,580		31.00
43.00	04300	NURSERY	38,058	0	38,058		43.00
44.00	04400	SKILLED NURSING FACILITY	180,489	0	180,489		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	673,654	0	673,654		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	89,582	0	89,582		52.00
53.00	05300	ANESTHESIOLOGY	85,718	0	85,718		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	675,911	0	675,911		54.00
56.00	05600	RADIOISOTOPE	71,807	0	71,807		56.00
57.00	05700	CT SCAN	47,475	0	47,475		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	85,003	0	85,003		58.00
59.00	05900	CARDIAC CATHETERIZATION	51,500	0	51,500		59.00
60.00	06000	LABORATORY	224,531	0	224,531		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	18,603	0	18,603		63.00
65.00	06500	RESPIRATORY THERAPY	65,428	0	65,428		65.00
66.00	06600	PHYSICAL THERAPY	67,375	0	67,375		66.00
67.00	06700	OCCUPATIONAL THERAPY	15,161	0	15,161		67.00
68.00	06800	SPEECH PATHOLOGY	22,111	0	22,111		68.00
69.00	06900	ELECTROCARDIOLOGY	155,417	0	155,417		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	200,780	0	200,780		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	82,228	0	82,228		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	338,415	0	338,415		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	SLEEP LAB	7,220	0	7,220		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	28,414	0	28,414		90.00
91.00	09100	EMERGENCY	253,735	0	253,735		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	49,631	0	49,631		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,558,265	0	4,558,265		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	61,511	0	61,511		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	182,928	0	182,928		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	RENTED SPACE	42,467	0	42,467		194.01
194.02	07952	FOUNDATION	4,768	0	4,768		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	4,849,939	0	4,849,939		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B-1 | Date/Time Prepared: 9/15/2012 10:30 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	303,830					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,204,666				2.00
4.00	00400	EMPLOYEE BENEFITS	1,479	671	25,802,772			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	84,337	678,010	4,311,586	-10,922,935	45,844,909	5.00
7.00	00700	OPERATION OF PLANT	26,659	28,099	536,946	0	2,340,684	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	12,322	140,733	0	322,217	8.00
9.00	00900	HOUSEKEEPING	296	4,783	737,516	0	1,286,307	9.00
10.00	01000	DIETARY	6,568	17,017	173,287	0	525,814	10.00
11.00	01100	CAFETERIA	1,998	0	450,482	0	665,188	11.00
13.00	01300	NURSING ADMINISTRATION	4,231	66,123	927,775	0	1,268,741	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,199	67,401	74,314	0	154,310	14.00
15.00	01500	PHARMACY	1,700	14,425	770,531	0	1,281,056	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,165	22,488	635,110	0	911,142	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,764	61,408	5,228,162	0	6,982,837	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	7,579	1,197,503	0	1,559,430	31.00
43.00	04300	NURSERY	1,035	8,792	191,276	0	260,795	43.00
44.00	04400	SKILLED NURSING FACILITY	9,983	10,772	722,884	0	1,032,050	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,483	323,000	2,109,874	0	3,608,157	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	3,360	28,211	613,838	0	838,906	52.00
53.00	05300	ANESTHESIOLOGY	349	71,785	31,441	0	203,328	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	15,577	427,548	1,209,269	0	2,700,564	54.00
56.00	05600	RADIOISOTOPE	875	44,760	140,366	0	595,178	56.00
57.00	05700	CT SCAN	2,509	3,938	248,962	0	652,067	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,032	50,471	141,516	0	266,976	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	28,902	291,684	0	481,215	59.00
60.00	06000	LABORATORY	5,491	90,736	1,050,076	0	2,605,943	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	902	45,440	0	592,559	63.00
65.00	06500	RESPIRATORY THERAPY	1,526	23,560	408,396	0	577,625	65.00
66.00	06600	PHYSICAL THERAPY	3,950	2,280	0	0	895,594	66.00
67.00	06700	OCCUPATIONAL THERAPY	777	19	0	0	264,315	67.00
68.00	06800	SPEECH PATHOLOGY	1,819	0	0	0	169,751	68.00
69.00	06900	ELECTROCARDIOLOGY	4,430	89,916	457,388	0	702,718	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,844,328	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	1,574,413	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,191,477	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	740	0	0	0	5,967	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,021	2,140	162,452	0	228,526	90.00
91.00	09100	EMERGENCY	14,223	14,319	2,235,373	0	2,981,864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,862	406	542,414	0	1,025,761	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	273,941	2,202,783	25,786,594	-10,922,935	45,597,803	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	6,147	1,626	16,178	0	68,511	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,830	257	0	0	141,699	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	4,416	0	0	0	33,170	194.01
194.02	07952	FOUNDATION	496	0	0	0	3,726	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,282,138	2,247,151	5,858,857		10,922,935	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.511233	1.019270	0.227063		0.238258	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			11,793		1,358,791	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000457		0.029639	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B-1 | Date/Time Prepared: 9/15/2012 10:30 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	191,355					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	702,581				8.00
9.00	00900	HOUSEKEEPING	296	5,716	187,307			9.00
10.00	01000	DIETARY	6,568	430	6,568	72,691		10.00
11.00	01100	CAFETERIA	1,998	0	1,998	0	39,545	11.00
13.00	01300	NURSING ADMINISTRATION	4,231	0	4,231	0	2,714	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,199	2,195	5,199	0	280	14.00
15.00	01500	PHARMACY	1,700	0	1,700	0	1,080	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,165	0	4,165	0	1,792	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,764	201,750	35,764	58,411	10,345	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	102,296	3,986	5,204	1,964	31.00
43.00	04300	NURSERY	1,035	11,125	1,035	0	352	43.00
44.00	04400	SKILLED NURSING FACILITY	9,983	76,570	9,983	9,076	1,554	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,483	86,634	20,483	0	3,907	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	3,360	35,702	3,360	0	1,130	52.00
53.00	05300	ANESTHESIOLOGY	349	0	349	0	1,102	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	15,577	48,566	15,577	0	2,636	54.00
56.00	05600	RADIOISOTOPE	875	0	875	0	193	56.00
57.00	05700	CT SCAN	2,509	0	2,509	0	411	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,032	3,375	2,032	0	346	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	0	765	0	428	59.00
60.00	06000	LABORATORY	5,491	153	5,491	0	2,298	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	99	63.00
65.00	06500	RESPIRATORY THERAPY	1,526	0	1,526	0	898	65.00
66.00	06600	PHYSICAL THERAPY	3,950	15,966	3,950	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	777	0	777	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,819	0	1,819	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,430	1,214	4,430	0	898	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	740	1,140	740	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,021	0	2,021	0	310	90.00
91.00	09100	EMERGENCY	14,223	89,012	14,223	0	3,794	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,862	0	1,862	0	934	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	161,466	681,844	157,418	72,691	39,465	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	6,147	0	6,147	0	80	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,830	20,529	18,830	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	4,416	208	4,416	0	0	194.01
194.02	07952	FOUNDATION	496	0	496	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,898,371	455,818	1,600,971	806,994	871,015	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.146565	0.648776	8.547310	11.101704	22.025920	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	312,067	56,474	46,464	94,718	38,683	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.630828	0.080381	0.248063	1.303022	0.978202	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B-1 | Date/Time Prepared: 9/15/2012 10:30 am

		Cost Center Description	NURSING ADMINISTRATION (PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	19,711					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,777,717				14.00
15.00	01500	PHARMACY	0	7,801	2,225,522			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,520	0	29,443		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,756	64,614	1,980	17,264		30.00
31.00	03100	INTENSIVE CARE UNIT	1,158	9,100	126	839		31.00
43.00	04300	NURSERY	847	1,973	32	1,264		43.00
44.00	04400	SKILLED NURSING FACILITY	2,950	8,569	0	392		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	78,375	0	6,209		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	6,330	104	0		52.00
53.00	05300	ANESTHESIOLOGY	0	8,366	15,788	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	25,580	2,063	0		54.00
56.00	05600	RADIOISOTOPE	0	174	573	0		56.00
57.00	05700	CT SCAN	0	1,357	215	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,617	6,843	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,856	0	0		59.00
60.00	06000	LABORATORY	0	21,784	129	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	128	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	6,389	80	2,375		65.00
66.00	06600	PHYSICAL THERAPY	0	5,840	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	543	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	17	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,889	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,844,328	0	0		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	1,574,413	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,195,582	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
76.00	03020	SLEEP LAB	0	89	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,693	0	0		90.00
91.00	09100	EMERGENCY	0	77,342	1,270	1,100		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	3,321	737	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,711	5,777,008	2,225,522	29,443		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	709	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	RENTED SPACE	0	0	0	0		194.01
194.02	07952	FOUNDATION	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,731,056	321,851	1,650,780	1,267,081		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	87.821825	0.055706	0.741750	43.035051		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	147,810	130,512	277,191	91,361		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.498859	0.022589	0.124551	3.102979		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet C Part I Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,545,096		12,545,096	0	12,545,096	30.00
31.00	03100	INTENSIVE CARE UNIT	2,331,224		2,331,224	0	2,331,224	31.00
43.00	04300	NURSERY	491,340		491,340	0	491,340	43.00
44.00	04400	SKILLED NURSING FACILITY	1,975,565		1,975,565	0	1,975,565	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,366,983		5,366,983	0	5,366,983	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	1,166,875		1,166,875	0	1,166,875	52.00
53.00	05300	ANESTHESIOLOGY	296,492		296,492	0	296,492	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	3,805,597		3,805,597	0	3,805,597	54.00
56.00	05600	RADIOISOTOPE	762,402		762,402	0	762,402	56.00
57.00	05700	CT SCAN	876,163		876,163	0	876,163	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	393,875		393,875	0	393,875	58.00
59.00	05900	CARDIAC CATHETERIZATION	623,524		623,524	0	623,524	59.00
60.00	06000	LABORATORY	3,408,957		3,408,957	0	3,408,957	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	735,929		735,929	0	735,929	63.00
65.00	06500	RESPIRATORY THERAPY	873,808	0	873,808	0	873,808	65.00
66.00	06600	PHYSICAL THERAPY	1,213,250	0	1,213,250	0	1,213,250	66.00
67.00	06700	OCCUPATIONAL THERAPY	345,730	0	345,730	0	345,730	67.00
68.00	06800	SPEECH PATHOLOGY	253,297	0	253,297	0	253,297	68.00
69.00	06900	ELECTROCARDIOLOGY	996,061		996,061	0	996,061	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,974,422		4,974,422	0	4,974,422	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	2,037,233		2,037,233	0	2,037,233	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,342,186		4,342,186	0	4,342,186	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.00	03020	SLEEP LAB	25,667		25,667	0	25,667	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	337,948		337,948	0	337,948	90.00
91.00	09100	EMERGENCY	4,223,219		4,223,219	0	4,223,219	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,632,180		1,632,180		1,632,180	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,335,579		1,335,579		1,335,579	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	57,370,602	0	57,370,602	0	57,370,602	200.00
201.00		Less Observation Beds	1,632,180		1,632,180		1,632,180	201.00
202.00		Total (see instructions)	55,738,422	0	55,738,422	0	55,738,422	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet C Part I Date/Time Prepared: 9/15/2012 10:30 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,353,222		17,353,222			30.00
31.00	03100	INTENSIVE CARE UNIT	2,888,423		2,888,423			31.00
43.00	04300	NURSERY	701,721		701,721			43.00
44.00	04400	SKILLED NURSING FACILITY	1,873,250		1,873,250			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,775,119	24,544,988	35,320,107	0.151953	0.000000	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	2,029,860	220,734	2,250,594	0.518474	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,488,990	2,430,154	3,919,144	0.075652	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	3,309,238	14,114,207	17,423,445	0.218418	0.000000	54.00
56.00	05600	RADIOISOTOPE	1,340,881	5,512,606	6,853,487	0.111243	0.000000	56.00
57.00	05700	CT SCAN	4,425,730	18,769,795	23,195,525	0.037773	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	494,919	5,371,725	5,866,644	0.067138	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,019,245	1,521,210	2,540,455	0.245438	0.000000	59.00
60.00	06000	LABORATORY	8,819,746	16,243,626	25,063,372	0.136014	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	750,640	333,921	1,084,561	0.678550	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	3,404,558	219,233	3,623,791	0.241131	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,882,511	1,378,559	3,261,070	0.372040	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	945,788	271,132	1,216,920	0.284102	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	123,216	204,872	328,088	0.772040	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,959,438	6,684,580	9,644,018	0.103283	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,655,660	3,325,309	10,980,969	0.453004	0.000000	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	4,337,582	1,322,923	5,660,505	0.359903	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,112,579	7,705,010	23,817,589	0.182310	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03020	SLEEP LAB	0	1,625,752	1,625,752	0.015788	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,504	1,398,625	1,400,129	0.241369	0.000000	90.00
91.00	09100	EMERGENCY	4,279,855	22,737,497	27,017,352	0.156315	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	255,766	2,344,977	2,600,743	0.627582	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,518,085	1,518,085			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	99,229,441	139,799,520	239,028,961			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	99,229,441	139,799,520	239,028,961			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet C Part I Date/Time Prepared: 9/15/2012 10:30 am

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		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
43.00	04300	NURSERY	
44.00	04400	SKILLED NURSING FACILITY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.151953
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.518474
53.00	05300	ANESTHESIOLOGY	0.075652
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.218418
56.00	05600	RADIOISOTOPE	0.111243
57.00	05700	CT SCAN	0.037773
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.067138
59.00	05900	CARDIAC CATHETERIZATION	0.245438
60.00	06000	LABORATORY	0.136014
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.678550
65.00	06500	RESPIRATORY THERAPY	0.241131
66.00	06600	PHYSICAL THERAPY	0.372040
67.00	06700	OCCUPATIONAL THERAPY	0.284102
68.00	06800	SPEECH PATHOLOGY	0.772040
69.00	06900	ELECTROCARDIOLOGY	0.103283
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.453004
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.359903
73.00	07300	DRUGS CHARGED TO PATIENTS	0.182310
74.00	07400	RENAL DIALYSIS	0.000000
76.00	03020	SLEEP LAB	0.015788
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.241369
91.00	09100	EMERGENCY	0.156315
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.627582
		OTHER REIMBURSABLE COST CENTERS	
101.00	10100	HOME HEALTH AGENCY	
		SPECIAL PURPOSE COST CENTERS	
113.00	11300	INTEREST EXPENSE	
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part I Date/Time Prepared: 9/15/2012 10:30 am

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	03000	ADULTS & PEDIATRICS	901,439	0	901,439	14,665	61.47	30.00
31.00	03100	INTENSIVE CARE UNIT	128,580		128,580	1,158	111.04	31.00
43.00	04300	NURSERY	38,058		38,058	847	44.93	43.00
44.00	04400	SKILLED NURSING FACILITY	180,489		180,489	2,950	61.18	44.00
200.00		Total (lines 30-199)	1,248,566		1,248,566	19,620		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part I Date/Time Prepared: 9/15/2012 10:30 am

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	03000	ADULTS & PEDIATRICS	7,086	435,576		30.00
31.00	03100	INTENSIVE CARE UNIT	621	68,956		31.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	2,390	146,220		44.00
200.00		Total (lines 30-199)	10,097	650,752		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part II Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	673,654	35,320,107	0.019073	4,738,200	90,372	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	89,582	2,250,594	0.039804	9,261	369	52.00
53.00	05300	ANESTHESIOLOGY	85,718	3,919,144	0.021872	501,168	10,962	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	675,911	17,423,445	0.038793	1,908,134	74,022	54.00
56.00	05600	RADIOISOTOPE	71,807	6,853,487	0.010477	786,191	8,237	56.00
57.00	05700	CT SCAN	47,475	23,195,525	0.002047	2,571,113	5,263	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	85,003	5,866,644	0.014489	275,158	3,987	58.00
59.00	05900	CARDIAC CATHETERIZATION	51,500	2,540,455	0.020272	730,606	14,811	59.00
60.00	06000	LABORATORY	224,531	25,063,372	0.008959	4,798,892	42,993	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	18,603	1,084,561	0.017153	464,549	7,968	63.00
65.00	06500	RESPIRATORY THERAPY	65,428	3,623,791	0.018055	1,992,231	35,970	65.00
66.00	06600	PHYSICAL THERAPY	67,375	3,261,070	0.020660	769,771	15,903	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,161	1,216,920	0.012459	195,621	2,437	67.00
68.00	06800	SPEECH PATHOLOGY	22,111	328,088	0.067394	67,621	4,557	68.00
69.00	06900	ELECTROCARDIOLOGY	155,417	9,644,018	0.016115	1,924,802	31,018	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	200,780	10,980,969	0.018284	4,220,758	77,172	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	82,228	5,660,505	0.014527	2,140,219	31,091	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	338,415	23,817,589	0.014209	8,186,082	116,316	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03020	SLEEP LAB	7,220	1,625,752	0.004441	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	28,414	1,400,129	0.020294	991	20	90.00
91.00	09100	EMERGENCY	253,735	27,017,352	0.009392	2,466,913	23,169	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	117,282	2,600,743	0.045096	161,213	7,270	92.00
200.00		Total (lines 50-199)	3,377,350	214,694,260		38,909,494	603,907	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part III Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part III Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Hospital | PPS

		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	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,665	0.00	7,086	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,158	0.00	621	0	0	31.00
43.00	04300	NURSERY	847	0.00	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,950	0.00	2,390	0	0	44.00
200.00		Total (lines 30-199)	19,620		10,097	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part III Date/Time Prepared: 9/15/2012 10:30 am

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	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
200.00		Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	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	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	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: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	35,320,107	0.000000	0.000000	4,738,200	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	2,250,594	0.000000	0.000000	9,261	52.00
53.00	05300	ANESTHESIOLOGY	0	3,919,144	0.000000	0.000000	501,168	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	17,423,445	0.000000	0.000000	1,908,134	54.00
56.00	05600	RADIOISOTOPE	0	6,853,487	0.000000	0.000000	786,191	56.00
57.00	05700	CT SCAN	0	23,195,525	0.000000	0.000000	2,571,113	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,866,644	0.000000	0.000000	275,158	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,540,455	0.000000	0.000000	730,606	59.00
60.00	06000	LABORATORY	0	25,063,372	0.000000	0.000000	4,798,892	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	1,084,561	0.000000	0.000000	464,549	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,623,791	0.000000	0.000000	1,992,231	65.00
66.00	06600	PHYSICAL THERAPY	0	3,261,070	0.000000	0.000000	769,771	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,216,920	0.000000	0.000000	195,621	67.00
68.00	06800	SPEECH PATHOLOGY	0	328,088	0.000000	0.000000	67,621	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,644,018	0.000000	0.000000	1,924,802	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,980,969	0.000000	0.000000	4,220,758	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	5,660,505	0.000000	0.000000	2,140,219	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,817,589	0.000000	0.000000	8,186,082	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03020	SLEEP LAB	0	1,625,752	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,400,129	0.000000	0.000000	991	90.00
91.00	09100	EMERGENCY	0	27,017,352	0.000000	0.000000	2,466,913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,600,743	0.000000	0.000000	161,213	92.00
200.00		Total (lines 50-199)	0	214,694,260			38,909,494	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	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	05000	OPERATING ROOM	0	5,936,357	0	0	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	4,275	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	717,110	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	3,511,794	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	2,203,018	0	0	0	56.00
57.00	05700	CT SCAN	0	6,534,800	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,572,840	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	897,964	0	0	0	59.00
60.00	06000	LABORATORY	0	368,708	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	244,409	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	89,767	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,323	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,685,446	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	944,041	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	489,793	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,441,555	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	0	325,863	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	96,354	0	0	0	90.00
91.00	09100	EMERGENCY	0	3,909,622	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	622,542	0	0	0	92.00
200.00		Total (lines 50-199)	0	33,597,581	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV Date/Time Prepared: 9/15/2012 10:30 am

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	05000	OPERATING ROOM	0	0		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	SLEEP LAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part V Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.151953	5,936,357	0	0		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.518474	4,275	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0.075652	717,110	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.218418	3,511,794	0	0		54.00
56.00	05600	RADIOISOTOPE	0.111243	2,203,018	0	0		56.00
57.00	05700	CT SCAN	0.037773	6,534,800	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.067138	1,572,840	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.245438	897,964	0	0		59.00
60.00	06000	LABORATORY	0.136014	368,708	265	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.678550	244,409	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0.241131	89,767	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.372040	1,323	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.284102	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0.772040	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0.103283	2,685,446	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.453004	944,041	0	0		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.359903	489,793	24,864	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.182310	2,441,555	0	0		73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0		74.00
76.00	03020	SLEEP LAB	0.015788	325,863	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.241369	96,354	0	0		90.00
91.00	09100	EMERGENCY	0.156315	3,909,622	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.627582	622,542	0	0		92.00
200.00		Subtotal (see instructions)		33,597,581	25,129	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		33,597,581	25,129	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part V Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: PPS Services (see instructions)	Costs: Cost Services Subject To Ded. & Coins. (see instructions)	Costs: Cost Services Not Subject To Ded. & Coins. (see instructions)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	902,047	0	0		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	2,216	0	0		52.00
53.00	05300	ANESTHESIOLOGY	54,251	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	767,039	0	0		54.00
56.00	05600	RADIOISOTOPE	245,070	0	0		56.00
57.00	05700	CT SCAN	246,839	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	105,597	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	220,394	0	0		59.00
60.00	06000	LABORATORY	50,149	36	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	165,844	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	21,646	0	0		65.00
66.00	06600	PHYSICAL THERAPY	492	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	277,361	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	427,654	0	0		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	176,278	8,949	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	445,120	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	SLEEP LAB	5,145	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	23,257	0	0		90.00
91.00	09100	EMERGENCY	611,133	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	390,696	0	0		92.00
200.00		Subtotal (see instructions)	5,138,228	8,985	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,138,228	8,985	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120 | Component CCN: 145766 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	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	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	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: 140120 | Component CCN: 145766 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	35,320,107	0.000000	0.000000	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	2,250,594	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,919,144	0.000000	0.000000	830	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	17,423,445	0.000000	0.000000	89,692	54.00
56.00	05600	RADIOISOTOPE	0	6,853,487	0.000000	0.000000	15,786	56.00
57.00	05700	CT SCAN	0	23,195,525	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,866,644	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,540,455	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	25,063,372	0.000000	0.000000	278,215	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	1,084,561	0.000000	0.000000	21,625	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,623,791	0.000000	0.000000	299,957	65.00
66.00	06600	PHYSICAL THERAPY	0	3,261,070	0.000000	0.000000	583,079	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,216,920	0.000000	0.000000	514,643	67.00
68.00	06800	SPEECH PATHOLOGY	0	328,088	0.000000	0.000000	22,035	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,644,018	0.000000	0.000000	15,737	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,980,969	0.000000	0.000000	558,970	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	5,660,505	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,817,589	0.000000	0.000000	1,295,852	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03020	SLEEP LAB	0	1,625,752	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,400,129	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	27,017,352	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,600,743	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	214,694,260			3,696,421	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120 | Component CCN: 145766 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	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	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	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: 140120 | Component CCN: 145766 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV | Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Skilled Nursing Facility | 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	05000	OPERATING ROOM	0	0		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	SLEEP LAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	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: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1 | Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,665	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,665	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	12,757	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)	7,086	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)	12,545,096	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)	12,545,096	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	17,359,720	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	17,359,720	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.722655	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)	1,360.80	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)	12,545,096	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)	855.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,061,648	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)	6,061,648	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1 | Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,331,224	1,158	2,013.15	621	1,250,166	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)	8,264,857	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	15,576,671	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)	504,532	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	603,907	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,108,439	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	14,468,232	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)	1,908	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	855.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,632,180	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1 | Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	901,439	12,545,096	0.071856	1,632,180	117,282	90.00
91.00	Nursing School cost	0	12,545,096	0.000000	1,632,180	0	91.00
92.00	Allied health cost	0	12,545,096	0.000000	1,632,180	0	92.00
93.00	All other Medical Education	0	12,545,096	0.000000	1,632,180	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140120 Component CCN: 145766	Period: From 05/01/2011 To 04/30/2012	Worksheet D-1 Date/Time Prepared: 9/15/2012 10:30 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,950	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,950	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,950	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)	2,390	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)	1,975,565	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)	1,975,565	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,871,775	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,871,775	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.055450	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)	634.50	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)	1,975,565	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140120 | Component CCN: 145766 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1 | Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	1,975,565	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	669.68	71.00
72.00	Program routine service cost (line 9 x line 71)	1,600,535	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,600,535	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,600,535	83.00
84.00	Program inpatient ancillary services (see instructions)	1,017,493	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,618,028	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: 140120 | Component CCN: 145766 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1 | Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	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: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-3 | Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,431,466		30.00
31.00	03100	INTENSIVE CARE UNIT		1,518,398		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.151953	4,738,200	719,984	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.518474	9,261	4,802	52.00
53.00	05300	ANESTHESIOLOGY	0.075652	501,168	37,914	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.218418	1,908,134	416,771	54.00
56.00	05600	RADIOISOTOPE	0.111243	786,191	87,458	56.00
57.00	05700	CT SCAN	0.037773	2,571,113	97,119	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.067138	275,158	18,474	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.245438	730,606	179,318	59.00
60.00	06000	LABORATORY	0.136014	4,798,892	652,716	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.678550	464,549	315,220	63.00
65.00	06500	RESPIRATORY THERAPY	0.241131	1,992,231	480,389	65.00
66.00	06600	PHYSICAL THERAPY	0.372040	769,771	286,386	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.284102	195,621	55,576	67.00
68.00	06800	SPEECH PATHOLOGY	0.772040	67,621	52,206	68.00
69.00	06900	ELECTROCARDIOLOGY	0.103283	1,924,802	198,799	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.453004	4,220,758	1,912,020	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.359903	2,140,219	770,271	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.182310	8,186,082	1,492,405	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03020	SLEEP LAB	0.015788	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.241369	991	239	90.00
91.00	09100	EMERGENCY	0.156315	2,466,913	385,616	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.627582	161,213	101,174	92.00
200.00		Total (sum of lines 50-94 and 96-98)		38,909,494	8,264,857	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		38,909,494		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140120 | Component CCN: 145766 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-3 | Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.151953	0	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.518474	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.075652	830	63	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.218418	89,692	19,590	54.00
56.00	05600	RADIOISOTOPE	0.111243	15,786	1,756	56.00
57.00	05700	CT SCAN	0.037773	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.067138	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.245438	0	0	59.00
60.00	06000	LABORATORY	0.136014	278,215	37,841	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.678550	21,625	14,674	63.00
65.00	06500	RESPIRATORY THERAPY	0.241131	299,957	72,329	65.00
66.00	06600	PHYSICAL THERAPY	0.372040	583,079	216,929	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.284102	514,643	146,211	67.00
68.00	06800	SPEECH PATHOLOGY	0.772040	22,035	17,012	68.00
69.00	06900	ELECTROCARDIOLOGY	0.103283	15,737	1,625	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.453004	558,970	253,216	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.359903	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.182310	1,295,852	236,247	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03020	SLEEP LAB	0.015788	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.241369	0	0	90.00
91.00	09100	EMERGENCY	0.156315	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.627582	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,696,421	1,017,493	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,696,421		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet E Part A Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Hospital | PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS			
1.00	DRG Amounts Other than Outlier Payments	9,910,427		1.00
2.00	Outlier payments for discharges. (see instructions)	213,023		2.00
2.01	For inpatient PPS services rendered during the cost reporting period enter the operating outlier reconciliation amount for operating expenses from line 92.	0		2.01
3.00	Managed Care Simulated Payments	0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	92.79		4.00
	Indirect Medical Education Adjustment			
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.	0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00		11.00
12.00	Current year allowable FTE (see instructions)	0.00		12.00
13.00	Total allowable FTE count for the prior year.	0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00		15.00
16.00	Adjustment for residents in initial years of the program	0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure	0.00		17.00
18.00	Adjusted rolling average FTE count	0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000		21.00
22.00	IME payment adjustment (see instructions)	0		22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000		26.00
27.00	IME payments adjustment. (see instructions)	0.000000		27.00
28.00	IME Adjustment (see instructions)	0		28.00
29.00	Total IME payment (sum of lines 22 and 28)	0		29.00
	Disproportionate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.91		30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)	16.93		31.00
32.00	Sum of lines 30 and 31	19.84		32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.65		33.00
34.00	Disproportionate share adjustment (see instructions)	559,939		34.00
	Additional payment for high percentage of ESRD beneficiary discharges			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)	0		46.00
47.00	Subtotal (see instructions)	10,683,389		47.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140120	Period: From 05/01/2011 To 04/30/2012	Worksheet E Part A Date/Time Prepared: 9/15/2012 10:30 am
	Title XVIII	Hospital	PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	10,683,389		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	815,050		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)	0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).	0		52.00
53.00	Nursing and Allied Health Managed Care payment	0		53.00
54.00	Special add-on payments for new technologies	0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	0		56.00
57.00	Routine service other pass through costs	0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	0		58.00
59.00	Total (sum of amounts on lines 49 through 58)	11,498,439		59.00
60.00	Primary payer payments	23,673		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	11,474,766		61.00
62.00	Deductibles billed to program beneficiaries	1,356,824		62.00
63.00	Coinsurance billed to program beneficiaries	17,913		63.00
64.00	Allowable bad debts (see instructions)	229,755		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	160,829		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	179,702		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	10,260,858		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0		68.00
69.00	Enter the time value of money for operating expenses, the capital outlier reconciliation amount and time value of money for capital related expenses by entering the sum of lines 93, 95 and 96. For SCH, if the hospital specific payment amount on line 48, is greater than the federal specific payment amount on line 47, do not complete this line.	0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		70.00
70.95	Recovery of Accelerated Depreciation	0		70.95
70.96	Low Volume Payment-1	0		70.96
70.97	Low Volume Payment-2	0		70.97
70.98	Low Volume Payment-3	0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	10,260,858		71.00
72.00	Interim payments	10,225,879		72.00
73.00	Tentative settlement (for contractor use only)	0		73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	34,979		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	22,793		75.00
	TO BE COMPLETED BY CONTRACTOR			
90.00	Operating outlier amount from Worksheet E, Part A line 2	0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0		93.00
94.00	The rate used to calculate the Time Value of Money	0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)	0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140120	Period: From 05/01/2011 To 04/30/2012	Worksheet E Part B Date/Time Prepared: 9/15/2012 10:30 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,985	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,138,228	2.00
3.00	PPS payments	5,125,134	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)	8,985	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	25,129	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)	25,129	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 chargebasis 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)	25,129	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	16,144	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)	8,985	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)	5,125,134	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	4,973	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,338,629	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)	3,790,517	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)	3,790,517	30.00
31.00	Primary payer payments	28	31.00
32.00	Subtotal (line 30 minus line 31)	3,790,489	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)	201,434	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	141,004	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	168,369	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	3,931,493	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)	3,931,493	40.00
41.00	Interim payments	3,875,188	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)	56,305	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: 140120	Period: From 05/01/2011 To 04/30/2012	Worksheet E Part B Date/Time Prepared: 9/15/2012 10:30 am
	Title XVIII	Hospital	PPS

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,173,990		3,917,388	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	02/17/2012	51,889		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	02/17/2012	42,200	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)		51,889		-42,200	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)		10,225,879		3,875,188	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		34,979		56,305	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		10,260,858		3,931,493	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140120	Period:	Worksheet E-1
Component CCN: 145766	From 05/01/2011	Part I
	To 04/30/2012	Date/Time Prepared: 9/15/2012 10:30 am
Title XVIII	Skilled Nursing Facility	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		797,942		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		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		797,942		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		797,942		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: 140120 Component CCN: 145766	Period: From 05/01/2011 To 04/30/2012	Worksheet E-3 Part VI Date/Time Prepared: 9/15/2012 10:30 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	836,159	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	836,159	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	38,217	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	797,942	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	797,942	15.00
16.00	Interim payments	797,942	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet G | Date/Time Prepared: 9/15/2012 10:30 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURENT ASSETS					
1.00	Cash on hand in banks	3,851,597	0	0	0	1.00
2.00	Temporary investments	4,287,383	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,334,279	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,013,765	0	0	0	7.00
8.00	Prepaid expenses	2,529,269	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	439,561	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	23,455,854	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,449,581	0	0	0	12.00
13.00	Land improvements	1,801,151	0	0	0	13.00
14.00	Accumulated depreciation	-1,492,293	0	0	0	14.00
15.00	Buildings	11,554,361	0	0	0	15.00
16.00	Accumulated depreciation	-8,226,016	0	0	0	16.00
17.00	Leasehold improvements	18,640,556	0	0	0	17.00
18.00	Accumulated depreciation	-13,596,668	0	0	0	18.00
19.00	Fixed equipment	14,765,261	0	0	0	19.00
20.00	Accumulated depreciation	-11,496,645	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	25,537,479	0	0	0	23.00
24.00	Accumulated depreciation	-17,753,678	0	0	0	24.00
25.00	Minor equipment depreciable	1,271,806	0	0	0	25.00
26.00	Accumulated depreciation	-815,316	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	706,996	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	22,346,575	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	23,208,460	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	3,211,502	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	26,419,962	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	72,222,391	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,779,236	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,109,132	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	3,087,327	0	0	0	43.00
44.00	Other current liabilities	5,098,894	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,074,589	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	20,148,145	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	7,133,380	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	27,281,525	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	42,356,114	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	29,866,277				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	29,866,277	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	72,222,391	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet G-1 | Date/Time Prepared: 9/15/2012 10:30 am

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		31,723,979		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,712,088				2.00
3.00	Total (sum of line 1 and line 2)		36,436,067		0		3.00
4.00	TEMPORARILY RESTRICTED NET ASSETS	512,604		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)		512,604		0		10.00
11.00	Subtotal (line 3 plus line 10)		36,948,671		0		11.00
12.00	CHANGE IN MINIMUM PENSION LIABILITY	3,622,500		0			12.00
13.00	TRANSFERS TO AFFILIATES	3,459,894		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)		7,082,394		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		29,866,277		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet G-1 | Date/Time Prepared: 9/15/2012 10:30 am

		Endowment Fund		Plant Fund			
		5.00	6.00	7.00	8.00		
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)		0		0		3.00
4.00	TEMPORARILY RESTRICTED NET ASSETS	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)		0		0		11.00
12.00	CHANGE IN MINIMUM PENSION LIABILITY	0		0			12.00
13.00	TRANSFERS TO AFFILIATES	0		0			13.00
14.00		0		0			14.00
15.00		0		0			15.00
16.00		0		0			16.00
17.00		0		0			17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet G-2 Parts | Date/Time Prepared: 9/15/2012 10:30 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	18,054,943		18,054,943	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	1,873,250		1,873,250	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	19,928,193		19,928,193	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,888,423		2,888,423	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)	2,888,423		2,888,423	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,816,616		22,816,616	17.00
18.00	Ancillary services	71,507,283	115,228,950	186,736,233	18.00
19.00	Outpatient services	4,537,125	26,481,099	31,018,224	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		1,518,085	1,518,085	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL CHARGES	3,932,337	6,089,025	10,021,362	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	102,793,361	149,317,159	252,110,520	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		64,938,791		29.00
30.00		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)		64,938,791		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet G-3 | Date/Time Prepared: 9/15/2012 10:30 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	252,110,520	1.00
2.00	Less contractual allowances and discounts on patients' accounts	184,152,211	2.00
3.00	Net patient revenues (line 1 minus line 2)	67,958,309	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	64,938,791	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,019,518	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	789,892	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	2,439	13.00
14.00	Revenue from meals sold to employees and guests	543,402	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	7,920	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	32,521	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	2,749	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	73,862	22.00
23.00	Governmental appropriations	0	23.00
24.00	GAIN ON ASSET DISPOSAL	24,254	24.00
24.01	WELLNESS CENTER	19,488	24.01
24.02	AUTOPSY FEES	7,224	24.02
24.03	GRANT INCOME	425,455	24.03
24.04	MISCELLANEOUS INCOME	124,613	24.04
25.00	Total other income (sum of lines 6-24)	2,053,819	25.00
26.00	Total (line 5 plus line 25)	5,073,337	26.00
27.00	UNREALIZED LOSS ON INVESTEMENT	361,249	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	361,249	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,712,088	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2011 To 04/30/2012 | Worksheet H | Date/Time Prepared: 9/15/2012 10:30 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	145,712	0	46,307	29,606	24,649	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	319,434	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	215,939	0	7.00
8.00	Occupational Therapy	0	0	0	20,632	0	8.00
9.00	Speech Pathology	0	0	0	4,276	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	77,268	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	3,639	14,875	12.00
13.00	Drugs	0	0	0	0	737	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	542,414	0	46,307	274,092	40,261	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2011 To 04/30/2012 | Worksheet H | Date/Time Prepared: 9/15/2012 10:30 am

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		Total (sum of cols. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	246,274	0	246,274	0	246,274	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	319,434	0	319,434	0	319,434	6.00
7.00	Physical Therapy	215,939	0	215,939	0	215,939	7.00
8.00	Occupational Therapy	20,632	0	20,632	0	20,632	8.00
9.00	Speech Pathology	4,276	0	4,276	0	4,276	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	77,268	0	77,268	0	77,268	11.00
12.00	Supplies (see instructions)	18,514	-14,875	3,639	0	3,639	12.00
13.00	Drugs	737	0	737	0	737	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	903,074	-14,875	888,199	0	888,199	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 140120 HHA CCN: 147057

Period: From 05/01/2011 To 04/30/2012

Worksheet H-1 Part I Date/Time Prepared: 9/15/2012 10:30 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
			Bldgs & Fixtures	Movable Equipment			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0				1.00
2.00	Capital Related - Movable Equipment	0		0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	246,274	0	0	0	0	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	319,434	0	0	0	0	6.00
7.00	Physical Therapy	215,939	0	0	0	0	7.00
8.00	Occupational Therapy	20,632	0	0	0	0	8.00
9.00	Speech Pathology	4,276	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	77,268	0	0	0	0	11.00
12.00	Supplies (see instructions)	3,639	0	0	0	0	12.00
13.00	Drugs	737	0	0	0		13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	888,199	0	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 140120 HHA CCN: 147057 | Period: From 05/01/2011 To 04/30/2012 | Worksheet H-1 Part I Date/Time Prepared: 9/15/2012 10:30 am

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		Subtotal (cols. 0-4)	Administrative & General	Total (cols. 4A + 5)		
		4A.00	5.00	6.00		
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0				1.00
2.00	Capital Related - Movable Equipment	0				2.00
3.00	Plant Operation & Maintenance	0				3.00
4.00	Transportation					4.00
5.00	Administrative and General	246,274	246,274			5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	319,434	122,551	441,985		6.00
7.00	Physical Therapy	215,939	82,845	298,784		7.00
8.00	Occupational Therapy	20,632	7,915	28,547		8.00
9.00	Speech Pathology	4,276	1,640	5,916		9.00
10.00	Medical Social Services	0	0	0		10.00
11.00	Home Health Aide	77,268	29,644	106,912		11.00
12.00	Supplies (see instructions)	3,639	1,396	5,035		12.00
13.00	Drugs	737	283	1,020		13.00
14.00	DME	0	0	0		14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0		17.00
18.00	Clinic	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0		19.00
20.00	Day Care Program	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0		21.00
22.00	Homemaker Service	0	0	0		22.00
23.00	All Others (specify)	0	0	0		23.00
24.00	Total (sum of lines 1-23)	641,925		888,199		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140120 HHA CCN: 147057 | Period: From 05/01/2011 To 04/30/2012 | Worksheet H-1 Part II Date/Time Prepared: 9/15/2012 10:30 am

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		Capital Related Costs					
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		1.00	2.00	3.00	4.00	5A.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-246,274	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-246,274	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140120 HHA CCN: 147057 | Period: From 05/01/2011 To 04/30/2012 | Worksheet H-1 Part II Date/Time Prepared: 9/15/2012 10:30 am

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		Administrative & General (ACCUM. COST)		
		5.00		
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation (see instructions)			4.00
5.00	Administrative and General	641,925		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	319,434		6.00
7.00	Physical Therapy	215,939		7.00
8.00	Occupational Therapy	20,632		8.00
9.00	Speech Pathology	4,276		9.00
10.00	Medical Social Services	0		10.00
11.00	Home Health Aide	77,268		11.00
12.00	Supplies (see instructions)	3,639		12.00
13.00	Drugs	737		13.00
14.00	DME	0		14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0		15.00
16.00	Respiratory Therapy	0		16.00
17.00	Private Duty Nursing	0		17.00
18.00	Clinic	0		18.00
19.00	Health Promotion Activities	0		19.00
20.00	Day Care Program	0		20.00
21.00	Home Delivered Meals Program	0		21.00
22.00	Homemaker Service	0		22.00
23.00	All Others (specify)	0		23.00
24.00	Total (sum of lines 1-23)	641,925		24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	246,274		25.00
26.00	Unit Cost Multiplier	0.383649		26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140120 HHA CCN: 147057

Period: From 05/01/2011 To 04/30/2012

Worksheet H-2 Part I Date/Time Prepared: 9/15/2012 10:30 am

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PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General	0	13,986	414	33,086	47,486	1.00
2.00	Skilled Nursing Care	441,985	0	0	72,531	514,516	2.00
3.00	Physical Therapy	298,784	0	0	0	298,784	3.00
4.00	Occupational Therapy	28,547	0	0	0	28,547	4.00
5.00	Speech Pathology	5,916	0	0	0	5,916	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	106,912	0	0	17,545	124,457	7.00
8.00	Supplies (see instructions)	5,035	0	0	0	5,035	8.00
9.00	Drugs	1,020	0	0	0	1,020	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	888,199	13,986	414	123,162	1,025,761	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000	21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140120
HHA CCN: 147057

Period:
From 05/01/2011
To 04/30/2012

Worksheet H-2
Part I
Date/Time Prepared:
9/15/2012 10:30 am

Home Health Agency I

PPS

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	11,314	28,203	0	15,915	0	1.00
2.00	Skilled Nursing Care	122,586	0	0	0	0	2.00
3.00	Physical Therapy	71,188	0	0	0	0	3.00
4.00	Occupational Therapy	6,802	0	0	0	0	4.00
5.00	Speech Pathology	1,410	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	29,653	0	0	0	0	7.00
8.00	Supplies (see instructions)	1,200	0	0	0	0	8.00
9.00	Drugs	243	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	244,396	28,203	0	15,915	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140120 HHA CCN: 147057

Period: From 05/01/2011 To 04/30/2012

Worksheet H-2 Part I Date/Time Prepared: 9/15/2012 10:30 am

Home Health Agency I

PPS

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	20,572	0	185	547	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	20,572	0	185	547	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140120 HHA CCN: 147057

Period: From 05/01/2011 To 04/30/2012

Worksheet H-2 Part I Date/Time Prepared: 9/15/2012 10:30 am

Home Health Agency I

PPS

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	124,222	0	124,222			1.00
2.00	Skilled Nursing Care	637,102	0	637,102	65,333	702,435	2.00
3.00	Physical Therapy	369,972	0	369,972	37,940	407,912	3.00
4.00	Occupational Therapy	35,349	0	35,349	3,625	38,974	4.00
5.00	Speech Pathology	7,326	0	7,326	751	8,077	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	154,110	0	154,110	15,804	169,914	7.00
8.00	Supplies (see instructions)	6,235	0	6,235	639	6,874	8.00
9.00	Drugs	1,263	0	1,263	130	1,393	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,335,579	0	1,335,579	124,222	1,335,579	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.102548		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140120 HHA CCN: 147057

Period: From 05/01/2011 To 04/30/2012

Worksheet H-2 Part II Date/Time Prepared: 9/15/2012 10:30 am

Home Health Agency I

PPS

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	Administrative and General	1,862	406	145,712	0	47,486	1.00
2.00	Skilled Nursing Care	0	0	319,434	0	514,516	2.00
3.00	Physical Therapy	0	0	0	0	298,784	3.00
4.00	Occupational Therapy	0	0	0	0	28,547	4.00
5.00	Speech Pathology	0	0	0	0	5,916	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	77,268	0	124,457	7.00
8.00	Supplies (see instructions)	0	0	0	0	5,035	8.00
9.00	Drugs	0	0	0	0	1,020	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,862	406	542,414		1,025,761	20.00
21.00	Total cost to be allocated	13,986	414	123,162		244,396	21.00
22.00	Unit cost multiplier	7.511278	1.019704	0.227063		0.238258	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140120
HHA CCN: 147057

Period:
From 05/01/2011
To 04/30/2012

Worksheet H-2
Part II
Date/Time Prepared:
9/15/2012 10:30 am

Home Health Agency I

PPS

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	1,862	0	1,862	0	934	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,862	0	1,862	0	934	20.00
21.00	Total cost to be allocated	28,203	0	15,915	0	20,572	21.00
22.00	Unit cost multiplier	15.146617	0.000000	8.547261	0.000000	22.025696	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140120 HHA CCN: 147057

Period: From 05/01/2011 To 04/30/2012

Worksheet H-2 Part II Date/Time Prepared: 9/15/2012 10:30 am

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	Cost Center Description	NURSING ADMINISTRATION (PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
		13.00	14.00	15.00	16.00		
1.00	Administrative and General	0	3,321	737	0		1.00
2.00	Skilled Nursing Care	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0		8.00
9.00	Drugs	0	0	0	0		9.00
10.00	DME	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0		13.00
14.00	Clinic	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0		19.00
20.00	Total (sum of lines 1-19)	0	3,321	737	0		20.00
21.00	Total cost to be allocated	0	185	547	0		21.00
22.00	Unit cost multiplier	0.000000	0.055706	0.742198	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140120 | Period: From 05/01/2011 To 04/30/2012 | Worksheet H-3 Parts I-II | Date/Time Prepared: 9/15/2012 10:30 am

HHA CCN: 147057 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	2.00	702,435		702,435	4,808	1.00
2.00	Physical Therapy	3.00	407,912	0	407,912	3,314	2.00
3.00	Occupational Therapy	4.00	38,974	0	38,974	286	3.00
4.00	Speech Pathology	5.00	8,077	0	8,077	79	4.00
5.00	Medical Social Services	6.00	0		0	0	5.00
6.00	Home Health Aide	7.00	169,914		169,914	1,163	6.00
7.00	Total (sum of lines 1-6)		1,327,312	0	1,327,312	9,650	7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care		37900	1,863	909		8.00
8.01	Skilled Nursing Care		99914	176	88		8.01
9.00	Physical Therapy		37900	1,357	553		9.00
9.01	Physical Therapy		99914	116	35		9.01
10.00	Occupational Therapy		37900	86	63		10.00
10.01	Occupational Therapy		99914	2	4		10.01
11.00	Speech Pathology		37900	46	5		11.00
11.01	Speech Pathology		99914	5	0		11.01
12.00	Medical Social Services		37900	0	0		12.00
12.01	Medical Social Services		99914	0	0		12.01
13.00	Home Health Aide		37900	461	333		13.00
13.01	Home Health Aide		99914	56	22		13.01
14.00	Total (sum of lines 8-13)			4,168	2,012		14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	8.00	6,874	5,217	12,091	11,516	15.00
16.00	Cost of Drugs	9.00	1,393	0	1,393	1,573	16.00

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	
		0	1.00	2.00	3.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS					
1.00	Physical Therapy	66.00	0.372040	0	0	1.00
2.00	Occupational Therapy	67.00	0.284102	0	0	2.00
3.00	Speech Pathology	68.00	0.772040	0	0	3.00
4.00	Cost of Medical Supplies	71.00	0.453004	11,516	5,217	4.00
5.00	Cost of Drugs	73.00	0.182310	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2011 To 04/30/2012 | Worksheet H-3 Parts I-II | Date/Time Prepared: 9/15/2012 10:30 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	146.10	2,039	997			1.00
2.00	Physical Therapy	123.09	1,473	588			2.00
3.00	Occupational Therapy	136.27	88	67			3.00
4.00	Speech Pathology	102.24	51	5			4.00
5.00	Medical Social Services	0.00	0	0			5.00
6.00	Home Health Aide	146.10	517	355			6.00
7.00	Total (sum of lines 1-6)		4,168	2,012			7.00

	Cost Center Description	Program Covered Charges: Ratio (col. 3 ÷ col. 4)	Program Covered Charges: Part A	Program Covered Charges: Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00	9.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
14.00	Total (sum of lines 8-13)						14.00

	Cost Center Description	Ratio (col. 3 ÷ col. 4)	Program Covered Charges: Part A	Program Covered Charges: Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00		
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	1.049931					15.00
16.00	Cost of Drugs	0.885569	0	472	0		16.00

	Cost Center Description	Transfer to Part I as Indicated	
		4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS		
1.00	Physical Therapy	col. 2, line 2.00	1.00
2.00	Occupational Therapy	col. 2, line 3.00	2.00
3.00	Speech Pathology	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	col. 2, line 15.00	4.00
5.00	Cost of Drugs	col. 2, line 16.00	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2011 To 04/30/2012 | Worksheet H-3 Parts I-II | Date/Time Prepared: 9/15/2012 10:30 am

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	Cost Center Description	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols. 9-10)		
		9.00	10.00	11.00	12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	297,898	145,662		443,560		1.00
2.00	Physical Therapy	181,312	72,377		253,689		2.00
3.00	Occupational Therapy	11,992	9,130		21,122		3.00
4.00	Speech Pathology	5,214	511		5,725		4.00
5.00	Medical Social Services	0	0		0		5.00
6.00	Home Health Aide	75,534	51,866		127,400		6.00
7.00	Total (sum of lines 1-6)	571,950	279,546		851,496		7.00

	Cost Center Description						
		10.00	11.00	12.00			
	Limitation Cost Computation						
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
14.00	Total (sum of lines 8-13)						14.00

	Cost Center Description	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance			
		9.00	10.00	11.00			
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies						15.00
16.00	Cost of Drugs	0	418	0			16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2011 To 04/30/2012 | Worksheet H-4 Part I-II | Date/Time Prepared: 9/15/2012 10:30 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	418	0	1.00
2.00	Total charges	0	472	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	472	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	54	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	418	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	605,897	276,847	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	7,113	3,563	13.00
14.00	Total PPS Reimbursement - PEP Episodes	6,150	6,233	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	619,160	287,061	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	619,160	287,061	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	619,160	287,061	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	619,160	287,061	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	619,160	287,061	31.00
32.00	Interim payments (see instructions)	619,160	286,879	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)	0	182	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 140120 HHA CCN: 147057 | Period: From 05/01/2011 To 04/30/2012 | Worksheet H-5 | Date/Time Prepared: 9/15/2012 10:30 am

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		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		619,160		286,879	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			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			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		619,160		286,879	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			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		0		182	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		619,160		287,061	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140120	Period: From 05/01/2011 To 04/30/2012	Worksheet L Parts I-III Date/Time Prepared: 9/15/2012 10:30 am
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		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	797,058	1.00
2.00	Capital DRG outlier payments	17,992	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	38.43	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)	0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)	815,050	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00