

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)).  
 FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE  
 THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS  
 (42 USC 1395g).

WORKSHEET 5  
 PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	I	15-1306	I	FROM 1/ 1/2010	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 12/31/2010	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/31/2011 TIME 10:29

PART I - 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 BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE 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: BLOOMINGTON HOSPITAL ORANGE COUNTY 15-1306 FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2010 AND ENDING 12/31/2010 AND THAT 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, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

See qualification below:

*Larry Bailey*  
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)  
 CEO  
 TITLE  
 5/31/11  
 DATE

-----  
 ECR ENCRYPTION INFORMATION  
 DATE: 5/31/2011 TIME 10:29  
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PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
		1	A 2	B 3	4	0
1	HOSPITAL	0	169,669	840,321	0	0
3	SWING BED - SNF	0	37,989	0	0	0
100	TOTAL	0	207,658	840,321	0	0

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

MCRIF32 1.23.0.10 ~ 2552-96 25.0.123.2

The submitted cost report for Bloomington Hospital of Orange County (Provider Number 15-1306) for the cost reporting period beginning January 1, 2010 and ending December 31, 2010, contains certain costs allocated from the Corporate Home Office of Clarian Health Partners, Inc. It is our understanding that the home office cost reporting methodology was developed by the home office in consultation with the Fiscal Intermediary. The attached Certification Statement is limited to the reporting data elements directly incurred by the Hospital within its local operations and excludes any certification regarding costs and other data elements allocated to Bloomington Hospital of Orange County through the Clarian Health Partners home office cost report.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 642 WEST HOSPITAL ROAD P.O. BOX:  
 1 CITY: PAOLI STATE: IN ZIP CODE: 47454- COUNTY: ORANGE

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	PROVIDER NO. 2	NPI NUMBER 2.01	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)		
					V 4	XVIII 5	XIX 6
02.00 HOSPITAL	BLOOMINGTON HOSPITAL ORANGE COUNTY	15-1306		7/ 1/2001	N	O	P
04.00 SWING BED - SNF	BHOC SWING BEDS	15-Z306		7/ 1/2001	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2010 TO: 12/31/2010

18 TYPE OF CONTROL 1 2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1  
 20 SUBPROVIDER

OTHER INFORMATION

21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.

21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. N

21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).

21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2

21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2

21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2

21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION (OR APPLICABLE EXTENSION) OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105, MIPPA §147, ACA §3121 OR MMEA §108? "Y" FOR YES, AND "N" FOR NO. N

21.07 DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER IN COL 1 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 OR MMEA §108? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. (SEE INSTRUCTIONS) N N

21.08 WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEEDING COST REPORTING PERIOD? ENTER IN COLUMN 2, "Y" FOR YES OR "N" FOR NO. 2 Y

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N

23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N

23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. / / / /

23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY) / /

24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). / /

25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R? N

25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4? N

25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II. N

25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. N

25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N

25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(b)? ENTER "Y" FOR YES OR "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)

25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(c)? ENTER "Y" FOR YES OR "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)

25.07 HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THE COST REPORTING PERIOD? ENTER "Y" FOR YES OR "N" FOR NO IN COLUMN 1.

25.08 IF LINE 25.07 IS YES, ENTER IN COLUMN 1 THE UNWEIGHTED NUMBER OF NON-PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. 0.00

IF LINE 25.07 IS YES, USE LINES 25.09 THROUGH 25.59 AS NECESSARY TO IDENTIFY THE PROGRAM NAME IN COLUMN 1, THE PROGRAM CODE IN COLUMN 2, AND THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENTS FTES BY PROGRAM IN COLUMN 3 FOR EACH PRIMARY CARE SPECIALTY PROGRAM IN WHICH RESIDENTS ARE TRAINED. (SEE INSTRUCTIONS)

25.09 0000 0.00

26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0

26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 7/ 1/2001

28 IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02

28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS) 1 2 3 4  
 0 0.0000 0.0000

28.02 ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY 0.00 0

A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 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. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)

28.03 STAFFING % Y/N 0.00%

28.04 RECRUITMENT 0.00%

28.05 RETENTION 0.00%

28.06 TRAINING 0.00%

29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? N

30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) Y

30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70 N

30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS) N

30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).

30.04 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II N

31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). Y

31.01 IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.02 IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.03 IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.04 IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.05 IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

MISCELLANEOUS COST REPORT INFORMATION

32 IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2. N  
 33 IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2. N  
 34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA? N  
 35 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N  
 35.01 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N  
 35.02 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?  
 35.03 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?  
 35.04 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) V XVIII XIX  
 1 2 3  
 36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS) N N N  
 37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N  
 37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE? N N N

TITLE XIX INPATIENT SERVICES

38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y  
 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? N  
 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? N  
 38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? N  
 38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? N

40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS). Y 15H059

40.01 NAME: CLARIAN HEALTH PARTNERS FI/CONTRACTOR NAME FI/CONTRACTOR #

40.02 STREET: 340 WEST TENTH STREET P.O. BOX:  
 40.03 CITY: INDIANAPOLIS, IN 46206 STATE: ZIP CODE: -

41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y  
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y  
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N  
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000  
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.  
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?  
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?  
 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?  
 46 IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "Y" FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION. ENTER "N" IF NOT EXEMPT. (SEE 42 CFR 413.13.)

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	1	2	3	4	5
47.00 HOSPITAL	Y	Y	Y	Y	Y
52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS)					
52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV					
53 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.					0
53.01 MDH PERIOD: BEGINNING: / / ENDING: / /					
54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:					
PREMIUMS:			0		
PAID LOSSES:			0		
AND/OR SELF INSURANCE:			0		
54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.					N
55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.					N

	DATE	Y OR N	LIMIT	Y OR N	FEES
	0	1	2	3	4
56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		N	0.00		0
56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?		N			
58 ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.		N			
58.01 IF LINE 58 COLUMN 1 IS Y, DOES 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. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y"FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).					
59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)		N			
60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)		N			
60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(c)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC).					0

MULTICAMPUS

61 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA? ENTER "Y" FOR YES AND "N" FOR NO.		N			
IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL.2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.					

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00

SETTLEMENT DATA

63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY).		Y			4/ 5/2011
---	--	---	--	--	-----------

MISCELLANEOUS DATA

64.00 DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO.		Y			
--	--	---	--	--	--

HOSPITAL AND HOSPITAL HEALTH CARE  
 COMPLEX STATISTICAL DATA

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	I/P DAYS / TITLE V	O/P VISITS / TITLE XVIII	TRIPS / TITLE XIX
1 ADULTS & PEDIATRICS	25	9,125	24,600.00	3	4	5
2 HMO					522	233
2 01 HMO - (IRF PPS SUBPROVIDER)						
3 ADULTS & PED-SB SNF					145	
4 ADULTS & PED-SB NF						
5 TOTAL ADULTS AND PEDS	25	9,125	24,600.00		667	233
11 NURSERY						182
12 TOTAL	25	9,125	24,600.00		667	415
13 RPCH VISITS						
25 TOTAL	25					
26 OBSERVATION BED DAYS						
27 AMBULANCE TRIPS						
28 EMPLOYEE DISCOUNT DAYS						
28 01 EMP DISCOUNT DAYS -IRF						
29 LABOR & DELIVERY DAYS						

COMPONENT	TITLE XIX OBSERVATION BEDS ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS / TOTAL ALL PATS 6	TRIPS / TOTAL OBSERVATION BEDS ADMITTED 6.01	TRIPS / TOTAL OBSERVATION BEDS NOT ADMITTED 6.02	INTERNS & RES. FTES -- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			1,025				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			162				
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS			1,187				
11 NURSERY			244				
12 TOTAL			1,431				
13 RPCH VISITS							
25 TOTAL							
26 OBSERVATION BED DAYS			1,161				
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	I & R FTES NET 9	FULL TIME EMPLOYEES ON PAYROLL 10	EQUIV NONPAID WORKERS 11	DISCHARGES / TITLE V	DISCHARGES / TITLE XVIII	DISCHARGES / TITLE XIX	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS				12	13	14	15
2 HMO					201	166	422
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
11 NURSERY							
12 TOTAL		186.95			201	166	422
13 RPCH VISITS							
25 TOTAL		186.95					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/30/2011  
I 15-1306 I FROM 1/ 1/2010 I WORKSHEET A  
I I TO 12/31/2010 I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
0300	NEW CAP REL COSTS-BLDG & FIXT		375,157	375,157	121,768	496,925
0400	NEW CAP REL COSTS-MVBLE EQUIP		729,664	729,664	147,623	877,287
0500	EMPLOYEE BENEFITS	126,872	3,116,889	3,243,761	1,207	3,244,968
0600	ADMINISTRATIVE & GENERAL	1,338,767	1,314,502	2,653,269	13,709	2,666,978
0800	OPERATION OF PLANT	167,800	693,964	861,764		861,764
0900	LAUNDRY & LINEN SERVICE		66,570	66,570		66,570
1000	HOUSEKEEPING	164,291	40,207	204,498		204,498
1100	DIETARY	174,343	137,240	311,583	-210,984	100,599
1200	CAFETERIA				209,316	209,316
1400	NURSING ADMINISTRATION	726,866	17,827	744,693	-222,635	522,058
1500	CENTRAL SERVICES & SUPPLY	47,867	71,426	119,293	-24,858	94,435
1600	PHARMACY	267,195	1,191,121	1,458,316	-1,171,144	287,172
1700	MEDICAL RECORDS & LIBRARY	292,287	137,528	429,815		429,815
2500	INPAT ROUTINE SRVC CNTRS					
ADULTS & PEDIATRICS		977,008	166,697	1,143,705	-49,432	1,094,273
3300	NURSERY	85,673	14,593	100,266	-8,801	91,465
	ANCILLARY SRVC COST CNTRS					
3700	OPERATING ROOM	596,328	444,241	1,040,569	-198,896	841,673
3900	DELIVERY ROOM & LABOR ROOM	112,587		112,587	7,612	120,199
4100	RADIOLOGY-DIAGNOSTIC	628,184	575,557	1,203,741	-13,236	1,190,505
4400	LABORATORY	681,195	638,955	1,320,150		1,320,150
4800	INTRAVENOUS THERAPY	47,017	17,927	64,944	55,679	120,623
4900	RESPIRATORY THERAPY	174,907	36,162	211,069	-30,819	180,250
5000	PHYSICAL THERAPY	357,360	39,981	397,341	-18,772	378,569
5500	MEDICAL SUPPLIES CHARGED TO PATIENTS				356,219	356,219
55.30	IMPL. DEV. CHARGED TO PATIENT				17,410	17,410
5600	DRUGS CHARGED TO PATIENTS				1,102,187	1,102,187
59.97	ACUPUNCTURE					
3997	CARDIAC REHABILITATION	57,621	9,014	66,635	-461	66,174
	OUTPAT SERVICE COST CNTRS					
6100	EMERGENCY	2,232,705	285,948	2,518,653	-75,754	2,442,899
6200	OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
6500	AMBULANCE SERVICES	798,618	137,439	936,057	-8,936	927,121
	SPEC PURPOSE COST CENTERS					
8800	INTEREST EXPENSE		56,329	56,329	-56,329	
9000	OTHER CAPITAL RELATED COSTS		47,416	47,416	-47,416	
95	SUBTOTALS	10,055,491	10,362,354	20,417,845	-105,743	20,312,102
	NONREIMBURS COST CENTERS					
7950	FOUNDATION	34,212	2,545	36,757		36,757
100.01	7951 OUTREACH	88,285	26,999	115,284	91,970	207,254
100.02	7952 SPRING VALLEY FAMILY PRACTICE		30,708	30,708	9,582	40,290
100.03	7953 PAOLI FAMILY PRACTICE		5,349	5,349	4,191	9,540
100.04	7954 VISITING SPECIALIST CLINIC	138,585	10,106	148,691		148,691
101	TOTAL	10,316,573	10,438,061	20,754,634	-0-	20,754,634

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/30/2011  
I 15-1306 I FROM 1/ 1/2010 I WORKSHEET A  
I I TO 12/31/2010 I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
0300	NEW CAP REL COSTS-BLDG & FIXT	71,390	568,315
4 0400	NEW CAP REL COSTS-MVBLE EQUIP	486,743	1,364,030
5 0500	EMPLOYEE BENEFITS	248,411	3,493,379
6 0600	ADMINISTRATIVE & GENERAL	1,618,936	4,285,914
8 0800	OPERATION OF PLANT	130,489	992,253
9 0900	LAUNDRY & LINEN SERVICE	24,963	91,533
10 1000	HOUSEKEEPING	24,285	228,783
11 1100	DIETARY		100,599
12 1200	CAFETERIA	-29,032	180,284
14 1400	NURSING ADMINISTRATION		522,058
15 1500	CENTRAL SERVICES & SUPPLY	-7,038	87,397
16 1600	PHARMACY		287,172
17 1700	MEDICAL RECORDS & LIBRARY	-10,934	418,881
	INPAT ROUTINE SRVC CNTRS		
25 2500	ADULTS & PEDIATRICS	-48,504	1,045,769
33 3300	NURSERY		91,465
	ANCILLARY SRVC COST CNTRS		
37 3700	OPERATING ROOM		841,673
39 3900	DELIVERY ROOM & LABOR ROOM		120,199
41 4100	RADIOLOGY-DIAGNOSTIC	-9,555	1,180,950
44 4400	LABORATORY		1,320,150
48 4800	INTRAVENOUS THERAPY		120,623
49 4900	RESPIRATORY THERAPY		180,250
50 5000	PHYSICAL THERAPY		378,569
55 5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		356,219
55.30 5530	IMPL. DEV. CHARGED TO PATIENT		17,410
56 5600	DRUGS CHARGED TO PATIENTS	36,033	1,138,220
59 3020	ACUPUNCTURE		
59.97 3997	CARDIAC REHABILITATION		66,174
	OUTPAT SERVICE COST CNTRS		
61 6100	EMERGENCY	-1,069,193	1,373,706
62 6200	OBSERVATION BEDS (NON-DISTINCT PART)		
	OTHER REIMBURS COST CNTRS		
65 6500	AMBULANCE SERVICES	-6,160	920,961
	SPEC PURPOSE COST CENTERS		
88 8800	INTEREST EXPENSE		-0-
90 9000	OTHER CAPITAL RELATED COSTS		-0-
95	SUBTOTALS	1,460,834	21,772,936
	NONREIMBURS COST CENTERS		
7950	FOUNDATION		36,757
100.01 7951	OUTREACH		207,254
100.02 7952	SPRING VALLEY FAMILY PRACTICE		40,290
100.03 7953	PAOLI FAMILY PRACTICE		9,540
100.04 7954	VISITING SPECIALIST CLINIC		148,691
101	TOTAL	1,460,834	22,215,468

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
	NEW CAP REL COSTS-BLDG & FIXT	0300	
	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
33	NURSERY	3300	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
39	DELIVERY ROOM & LABOR ROOM	3900	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
48	INTRAVENOUS THERAPY	4800	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
55.30	IMPL. DEV. CHARGED TO PATIENT	5530	IMPL. DEV. CHARGED TO PATIENT
56	DRUGS CHARGED TO PATIENTS	5600	
59	ACUPUNCTURE	3020	ACUPUNCTURE
59.97	CARDIAC REHABILITATION	3997	CARDIAC REHABILITATION
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
100	FOUNDATION	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	OUTREACH	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	SPRING VALLEY FAMILY PRACTICE	7952	OTHER NONREIMBURSABLE COST CENTERS
100.03	PAOLI FAMILY PRACTICE	7953	OTHER NONREIMBURSABLE COST CENTERS
100.04	VISITING SPECIALIST CLINIC	7954	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151306	FROM 1/ 1/2010	5/30/2011
	TO 12/31/2010	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	INCREASE		SALARY	OTHER
			LINE NO	3		
	1	2	3	4	5	
1 INSURANCE RECLASSIFICATION	A	NEW CAP REL COSTS-MVBLE EQUIP	4			35,168
2		ADMINISTRATIVE & GENERAL	6			23
3		EMPLOYEE BENEFITS	5			1,207
4 PROPERTY TAX RECLASSIFICATION	B	NEW CAP REL COSTS-BLDG & FIXT	3			11,018
5 INTEREST RECLASSIFICATION	C	NEW CAP REL COSTS-MVBLE EQUIP	4			56,329
6 LEASE RECLASSIFICATION	D	NEW CAP REL COSTS-MVBLE EQUIP	4			56,383
7		NEW CAP REL COSTS-BLDG & FIXT	3			131,554
8						
9						
10						
11						
12						
13 MEDICAL SUPPLIES RECLASSIFICATION	E	MEDICAL SUPPLIES CHARGED TO PATIENTS	55			373,629
14						
15						
16						
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21						
22						
23						
24						
25 CAFETERIA RECLASSIFICATION	F	CAFETERIA	12	117,751		91,565
26 DRUG RECLASSIFICATION	G	DRUGS CHARGED TO PATIENTS	56			1,161,317
27 COO RECLASSIFICATION	H	ADMINISTRATIVE & GENERAL	6	145,240		
28		EMERGENCY	61	1,571		
29		OUTREACH	100.01	75,824		
30 NONREIMB DEPRECIATION RECLASS	I	PAOLI FAMILY PRACTICE	100.03			4,191
31		SPRING VALLEY FAMILY PRACTICE	100.02			257
32		AMBULANCE SERVICES	65			1,676
33		SPRING VALLEY FAMILY PRACTICE	100.02			9,325
34 IV MEDICINE RECLASSIFICATION	J	INTRAVENOUS THERAPY	48			59,130
35 AMBULANCE BUILDING RECLASSIFICATION	K	AMBULANCE SERVICES	65			5,612
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(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry. Transfer the amounts in columns 4, 5, 8, and 9 to worksheet A, column 4, lines as appropriate. See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

RECLASSIFICATIONS

PROVIDER NO:  
151306

PERIOD:  
FROM 1/ 1/2010  
TO 12/31/2010

PREPARED 5/30/2011  
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE		SALARY	OTHER	A-7 REF 10
			LINE NO	7			
	1	6			8	9	
1 INSURANCE RECLASSIFICATION	A	OTHER CAPITAL RELATED COSTS	90			36,398	12
2							
3							
4 PROPERTY TAX RECLASSIFICATION	B	OTHER CAPITAL RELATED COSTS	90			11,018	13
5 INTEREST RECLASSIFICATION	C	INTEREST EXPENSE	88			56,329	11
6 LEASE RECLASSIFICATION	D	OPERATING ROOM	37			20,991	10
7		RESPIRATORY THERAPY	49			360	10
8		PHARMACY	16			237	
9		RADIOLOGY-DIAGNOSTIC	41			12,365	
10		DIETARY	11			1,668	
11		CENTRAL SERVICES & SUPPLY	15			20,762	
12		ADMINISTRATIVE & GENERAL	6			131,554	
13 MEDICAL SUPPLIES RECLASSIFICATION	E	CENTRAL SERVICES & SUPPLY	15			4,096	
14		PHARMACY	16			9,590	
15		ADULTS & PEDIATRICS	25			44,201	
16		NURSERY	33			6,420	
17		OPERATING ROOM	37			177,905	
18		RADIOLOGY-DIAGNOSTIC	41			871	
19		INTRAVENOUS THERAPY	48			3,451	
20		RESPIRATORY THERAPY	49			30,459	
21		PHYSICAL THERAPY	50			2,626	
22		EMERGENCY	61			77,325	
23		AMBULANCE SERVICES	65			16,224	
24		CARDIAC REHABILITATION	59.97			461	
25 CAFETERIA RECLASSIFICATION	F	DIETARY	11		117,751	91,565	
26 DRUG RECLASSIFICATION	G	PHARMACY	16			1,161,317	
27 COO RECLASSIFICATION	H	NURSING ADMINISTRATION	14		222,635		
28							
29							
30 NONREIMB DEPRECIATION RECLASS	I	NEW CAP REL COSTS-BLDG & FIXT	3			4,191	9
31		NEW CAP REL COSTS-MVBLE EQUIP	4			257	9
32		NEW CAP REL COSTS-BLDG & FIXT	3			11,001	9
33							9
34 IV MEDICINE RECLASSIFICATION	J	DRUGS CHARGED TO PATIENTS	56			59,130	
35 AMBULANCE BUILDING RECLASSIFICATION	K	NEW CAP REL COSTS-BLDG & FIXT	3			5,612	9
36							
37 JOB OTHER EXPENSE RECLASSIFICATION	L	NURSERY	33			2,381	
38		ADULTS & PEDIATRICS	25			7,612	
39 ATHLETIC TRAINER RECLASSIFICATION	M	PHYSICAL THERAPY	50		16,146		
40 4 IMPLANTABLE DEVICES	N	MEDICAL SUPPLIES CHARGED TO PATIENTS	55			17,410	
36 TOTAL RECLASSIFICATIONS					356,532	2,025,787	

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry. Transfer the amounts in columns 4, 5, 8, and 9 to worksheet A, column 4, lines as appropriate. See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151306	FROM 1/ 1/2010	5/30/2011
	TO 12/31/2010	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: A  
EXPLANATION : INSURANCE RECLASSIFICATION

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	35,168
2.00	ADMINISTRATIVE & GENERAL	6	23
3.00	EMPLOYEE BENEFITS	5	1,207
TOTAL RECLASSIFICATIONS FOR CODE A			36,398

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
OTHER CAPITAL RELATED COSTS	90	36,398	
		0	
		0	
		36,398	

RECLASS CODE: B  
EXPLANATION : PROPERTY TAX RECLASSIFICATION

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	11,018
TOTAL RECLASSIFICATIONS FOR CODE B			11,018

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
OTHER CAPITAL RELATED COSTS	90	11,018	
		11,018	

RECLASS CODE: C  
EXPLANATION : INTEREST RECLASSIFICATION

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	56,329
TOTAL RECLASSIFICATIONS FOR CODE C			56,329

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
INTEREST EXPENSE	88	56,329	
		56,329	

RECLASS CODE: D  
EXPLANATION : LEASE RECLASSIFICATION

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	56,383
2.00	NEW CAP REL COSTS-BLDG & FIXT	3	131,554
3.00			0
4.00			0
5.00			0
6.00			0
7.00			0
TOTAL RECLASSIFICATIONS FOR CODE D			187,937

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
OPERATING ROOM	37	20,991	
RESPIRATORY THERAPY	49	360	
PHARMACY	16	237	
RADIOLOGY-DIAGNOSTIC	41	12,365	
DIETARY	11	1,668	
CENTRAL SERVICES & SUPPLY	15	20,762	
ADMINISTRATIVE & GENERAL	6	131,554	
		187,937	

RECLASS CODE: E  
EXPLANATION : MEDICAL SUPPLIES RECLASSIFICATION

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	373,629
2.00			0
3.00			0
4.00			0
5.00			0
6.00			0
7.00			0
8.00			0
9.00			0
10.00			0
11.00			0
12.00			0
TOTAL RECLASSIFICATIONS FOR CODE E			373,629

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
CENTRAL SERVICES & SUPPLY	15	4,096	
PHARMACY	16	9,590	
ADULTS & PEDIATRICS	25	44,201	
NURSERY	33	6,420	
OPERATING ROOM	37	177,905	
RADIOLOGY-DIAGNOSTIC	41	871	
INTRAVENOUS THERAPY	48	3,451	
RESPIRATORY THERAPY	49	30,459	
PHYSICAL THERAPY	50	2,626	
EMERGENCY	61	77,325	
AMBULANCE SERVICES	65	16,224	
CARDIAC REHABILITATION	59.97	461	
		373,629	

RECLASS CODE: F  
EXPLANATION : CAFETERIA RECLASSIFICATION

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	209,316
TOTAL RECLASSIFICATIONS FOR CODE F			209,316

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
DIETARY	11	209,316	
		209,316	

RECLASS CODE: G  
EXPLANATION : DRUG RECLASSIFICATION

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	56	1,161,317
TOTAL RECLASSIFICATIONS FOR CODE G			1,161,317

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
PHARMACY	16	1,161,317	
		1,161,317	

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151306	FROM 1/ 1/2010	5/30/2011
	TO 12/31/2010	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: H  
EXPLANATION : COO RECLASSIFICATION

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ADMINISTRATIVE & GENERAL	6	145,240	NURSING ADMINISTRATION	14	222,635	
2.00	EMERGENCY	61	1,571			0	
3.00	OUTREACH	100.01	75,824			0	
TOTAL RECLASSIFICATIONS FOR CODE H			222,635				222,635

RECLASS CODE: I  
EXPLANATION : NONREIMB DEPRECIATION RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	PAOLI FAMILY PRACTICE	100.03	4,191	NEW CAP REL COSTS-BLDG & FIXT	3	4,191	
2.00	SPRING VALLEY FAMILY PRACTICE	100.02	257	NEW CAP REL COSTS-MVBLE EQUIP	4	257	
3.00	AMBULANCE SERVICES	65	1,676	NEW CAP REL COSTS-BLDG & FIXT	3	11,001	
4.00	SPRING VALLEY FAMILY PRACTICE	100.02	9,325			0	
TOTAL RECLASSIFICATIONS FOR CODE I			15,449				15,449

RECLASS CODE: J  
EXPLANATION : IV MEDICINE RECLASSIFICATION

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	INTRAVENOUS THERAPY	48	59,130	DRUGS CHARGED TO PATIENTS	56	59,130	
TOTAL RECLASSIFICATIONS FOR CODE J			59,130				59,130

RECLASS CODE: K  
EXPLANATION : AMBULANCE BUILDING RECLASSIFICATION

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	AMBULANCE SERVICES	65	5,612	NEW CAP REL COSTS-BLDG & FIXT	3	5,612	
TOTAL RECLASSIFICATIONS FOR CODE K			5,612				5,612

RECLASS CODE: L  
EXPLANATION : OB OTHER EXPENSE RECLASSIFICATION

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ADULTS & PEDIATRICS	25	2,381	NURSERY	33	2,381	
2.00	DELIVERY ROOM & LABOR ROOM	39	7,612	ADULTS & PEDIATRICS	25	7,612	
TOTAL RECLASSIFICATIONS FOR CODE L			9,993				9,993

RECLASS CODE: M  
EXPLANATION : ATHLETIC TRAINER RECLASSIFICATION

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	OUTREACH	100.01	16,146	PHYSICAL THERAPY	50	16,146	
TOTAL RECLASSIFICATIONS FOR CODE M			16,146				16,146

RECLASS CODE: N  
EXPLANATION : IMPLANTABLE DEVICES

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	IMPL. DEV. CHARGED TO PATIENT	55.30	17,410	MEDICAL SUPPLIES CHARGED TO PA	55	17,410	
TOTAL RECLASSIFICATIONS FOR CODE N			17,410				17,410

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING	PURCHASES	ACQUISITIONS	TOTAL	DISPOSALS	ENDING	FULLY
		BALANCES		DONATION		AND		BALANCE
		1	2	3	4	5	6	7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT							
7	SUBTOTAL							
8	RECONCILING ITEMS							
9	TOTAL							

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING	PURCHASES	ACQUISITIONS	TOTAL	DISPOSALS	ENDING	FULLY
		BALANCES		DONATION		AND		BALANCE
		1	2	3	4	5	6	7
1	LAND	78,263					78,263	
2	LAND IMPROVEMENTS	508,587					508,587	
3	BUILDINGS & FIXTURE	6,195,636	220,987		220,987		6,416,623	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT	3,585,506	397,588		397,588		3,983,094	
6	MOVABLE EQUIPMENT	3,946,108	441,891		441,891	175,284	4,212,715	
7	SUBTOTAL	14,314,100	1,060,466		1,060,466	175,284	15,199,282	
8	RECONCILING ITEMS							
9	TOTAL	14,314,100	1,060,466		1,060,466	175,284	15,199,282	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	GROSS ASSETS 1	COMPUTATION OF RATIOS		RATIO 4	ALLOCATION OF OTHER CAPITAL			TOTAL 8
			CAPITLIZED LEASES 2	GROSS ASSETS FOR RATIO 3		INSURANCE 5	TAXES 6	OTHER CAPITAL RELATED COSTS 7	
3	NEW CAP REL COSTS-BL	7,003,473		7,003,473	.460777				
4	NEW CAP REL COSTS-MV	8,195,808		8,195,808	.539223				
5	TOTAL	15,199,281		15,199,281	1.000000				

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	425,743	131,554			11,018	568,315	
4	NEW CAP REL COSTS-MV	1,236,490	56,383	35,989	35,168		1,364,030	
5	TOTAL	1,662,233	187,937	35,989	35,168	11,018	1,932,345	

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	375,157					375,157	
4	NEW CAP REL COSTS-MV	729,664					729,664	
5	TOTAL	1,104,821					1,104,821	

\* All lines numbers except line 5 are to be consistent with workshheet A line numbers for capital cost centers.  
 (1) The amounts on lines 1 thru 4 must equal the corresponding amounts on worksheet A, column 7, lines 1 thru 4. Columns 9 through 14 should include related worksheet A-6 reclassifications and worksheet A-8 adjustments. (See instructions).

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: I  
I 15-1306 I  
I I

I PERIOD: I  
I FROM 1/ 1/2010 I  
I TO 12/31/2010 I

I PREPARED 5/30/2011  
I WORKSHEET A-8

DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		LINE NO 4	WKST. A-7 REF. 5
			COST CENTER 3			
1 INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**		1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**		2	
3 INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &		3	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP	B	-20,340	NEW CAP REL COSTS-MVBLE E		4	11
5 INVESTMENT INCOME-OTHER						
6 TRADE, QUANTITY AND TIME DISCOUNTS						
7 REFUNDS AND REBATES OF EXPENSES						
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS						
9 TELEPHONE SERVICES	B	-4,795	ADMINISTRATIVE & GENERAL		6	
10 TELEVISION AND RADIO SERVICE						
11 PARKING LOT						
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-1,127,252				
13 SALE OF SCRAP, WASTE, ETC.						
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1	2,824,587				
15 LAUNDRY AND LINEN SERVICE						
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-31,368	CAFETERIA		12	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS						
18 SALE OF MED AND SURG SUPPLIES	B	-7,038	CENTRAL SERVICES & SUPPLY		15	
19 SALE OF DRUGS TO OTHER THAN PATIENTS						
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-10,934	MEDICAL RECORDS & LIBRARY		17	
21 NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)						
22 VENDING MACHINES						
23 INCOME FROM IMPOSITION OF INTEREST						
24 INTRST EXP ON MEDICARE OVERPAYMENTS						
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY		49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY		50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3					
28 UTILIZATION REVIEW--PHYSIAN COMP			**COST CENTER DELETED**		89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**		1	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**		2	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &		3	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E		4	
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**		20	
34 PHYSICIANS' ASSISTANT						
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**		51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**		52	
37 VENDING MACHINE VOL SERVICES	B	-2,407	ADMINISTRATIVE & GENERAL		6	
38 MISCELLANEOUS REVENUE	B	-22,939	ADMINISTRATIVE & GENERAL		6	
EMT EDUCATION REVENUE	B	-5,860	AMBULANCE SERVICES		65	
41 BABY PHOTO REVENUE	B	-73	ADMINISTRATIVE & GENERAL		6	
42						
43 HRSA GRANT REVENUE	B	-23,101	ADMINISTRATIVE & GENERAL		6	
44 PHYSICIAN RECRUITMENT	A	-47,860	ADMINISTRATIVE & GENERAL		6	
45 AMA/IHA DUES	A	-1,505	ADMINISTRATIVE & GENERAL		6	
46 ADVERTISING	A	-20,797	ADMINISTRATIVE & GENERAL		6	
47 DONATIONS	A	-21,112	ADMINISTRATIVE & GENERAL		6	
48 PATIENT ACCTS MISC CASH REV	B	-8,385	ADMINISTRATIVE & GENERAL		6	
48.01 AMBULANCE OS PROGRAMS	B	-300	AMBULANCE SERVICES		65	
48.02 FUNDED DEPRECIATION INVEST FEES	A	-7,687	ADMINISTRATIVE & GENERAL		6	
49						
50 TOTAL (SUM OF LINES 1 THRU 49)		1,460,834				

- (1) Description - all chapter references in this column pertain to CMS Pub. 15-I.
  - (2) Basis for adjustment (see instructions).
    - A. Costs - if cost, including applicable overhead, can be determined.
    - B. Amount Received - if cost cannot be determined.
  - (3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.
- Note: See instructions for column 5 referencing to worksheet A-7

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	5	EMPLOYEE BENEFITS	BH MGMT SVC FEE	25,840	25,840	
2	6	ADMINISTRATIVE & GENERAL	BH MGMT SVC FEE	360,877	360,877	
3	4	NEW CAP REL COSTS-MVBLE E	BH MGMT SVC FEE	274,837	274,837	9
4	56	DRUGS CHARGED TO PATIENTS	BH MGMT SVC FEE	36,033	36,033	
4.01	9	LAUNDRY & LINEN SERVICE	BH MGMT SVC FEE	24,963	24,963	
4.02	3	NEW CAP REL COSTS-BLDG &	CHP MGMT SVC FEE	71,390	71,390	9
4.03	4	NEW CAP REL COSTS-MVBLE E	CHP MGMT SVC FEE	232,246	232,246	9
4.04	5	EMPLOYEE BENEFITS	CHP MGMT SVC FEE	222,571	222,571	
4.05	6	ADMINISTRATIVE & GENERAL	CHP MGMT SVC FEE	1,418,720	1,418,720	
4.06	8	OPERATION OF PLANT	CHP MGMT SVC FEE	130,489	130,489	
4.07	10	HOUSEKEEPING	CHP MGMT SVC FEE	24,285	24,285	
4.08	12	CAFETERIA	CHP MGMT SVC FEE	2,336	2,336	
4.09						
4.10						
5		TOTALS		2,824,587	2,824,587	

\* 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 ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:  
 THE SECRETARY, BY VIRTUE OF 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 & MEDICAID SERVICES AND ITS INTERMEDIARIES 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 REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
B		100.00	BLOOMINGTON HOSPITAL	0.00	HOSPITAL
B		100.00	BLOOMINGTON HOSPITAL	0.00	HOSPITAL
3 B		100.00	BLOOMINGTON HOSPITAL	0.00	HOSPITAL
4 B		0.00	CLARIAN HEALTH PARTNERS	0.00	CORPORATION
5		0.00		0.00	

- (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 A 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.
  - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY.

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO:  
I 15-1306  
I

I PERIOD:  
I FROM 1/ 1/2010  
I TO 12/31/2010

I PREPARED 5/30/2011  
I WORKSHEET A-8-2  
I GROUP 1

1	2	3	4	5	6	7	8	9
WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	61							
2	25	1,298,692	1,069,193	229,499				
3	41	48,504	48,504					
4	44	9,555	9,555					
5		25,000		25,000				
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	1,381,751	1,127,252	254,499				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I  
I 15-1306  
I

I PERIOD: I  
I FROM 1/ 1/2010  
I TO 12/31/2010

I PREPARED 5/30/2011  
I WORKSHEET A-8-2  
I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
10	11	12	13	14	15	16	17	18
1	61	EMERGENCY						
2	25	OBSTETRICS						1,069,193
3	41	RADIOLOGY						48,504
4	44	LABORATORY						9,555
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101		TOTAL						1,127,252

PHYSICAL THERAPY

RT I - GENERAL INFORMATION

1 TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) 46  
 (SEE INSTRUCTIONS)  
 2 LINE 1 MULTIPLIED BY 15 HOURS PER WEEK 690  
 3 NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR 75  
 OR THERAPIST WAS ON PROVIDER SITE  
 (SEE INSTRUCTIONS)  
 4 NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY  
 ASSISTANT WAS ON PROVIDER SITE BUT NEITHER  
 SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE  
 (SEE INSTRUCTIONS)  
 5 NUMBER OF UNDUPLICATED OFFSITE VISITS -  
 SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)  
 6 NUMBER OF UNDUPLICATED OFFSITE VISITS -  
 THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY  
 THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR  
 THERAPIST WAS NOT PRESENT DURING THE VISIT(S))  
 (SEE INSTRUCTIONS)  
 7 STANDARD TRAVEL EXPENSE RATE 4.82  
 8 OPTIONAL TRAVEL EXPENSE RATE PER MILE

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9 TOTAL HOURS WORKED		599.00			
10 AHSEA (SEE INSTRUCTIONS)		72.00			
11 STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	36.00	36.00			
12 NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01 NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13 NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01 NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

14 SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1,  
LINE 10)  
 THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2,  
LINE 10) 43,128  
 16 ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3,  
LINE 10)  
 17 SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT  
OR LINES 14-16 FOR ALL OTHERS ) 43,128  
 18 AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)  
 19 TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5,  
LINE 10)  
 20 TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT  
OR LINES 17 AND 18 FOR ALL OTHERS) 43,128

IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1-3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9, IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21-23.

21 WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES 72.00  
 (SEE INSTRUCTIONS)  
 22 WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES 49,680  
 (SEE INSTRUCTIONS)  
 23 TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS) 49,680

PART III - SALARY AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE  
 24 THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11) 2,700  
 25 ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)  
 26 SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS) 2,700  
 27 STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES  
3 AND 4) 362  
 28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD  
TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES  
26 AND 27) 3,062

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE  
 29 THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF  
COLUMNS 1 AND 2, LINE 12)  
 30 ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3,  
LINE 12)  
 31 SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)  
 32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2,  
LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)

PHYSICAL THERAPY

33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 3,062  
 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)  
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE  
 STANDARD TRAVEL EXPENSE

36 THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11)  
 37 ASSISTANTS (LINE 6 TIMES COLUMN 3, LINE 11)  
 38 SUBTOTAL (SUM OF LINES 36 AND 37)  
 39 STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF LINES 5 AND 6)  
 40 THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES COLUMN 2, LINE 10)  
 41 ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3, LINE 10)  
 42 SUBTOTAL (SUM OF LINES 40 AND 41)  
 43 OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF COLUMNS 1-3, LINE 13)  
 TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES;  
 COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE  
 44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 38 AND 39 - SEE INSTRUCTIONS)  
 45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 39 AND 42 - SEE INSTRUCTIONS)  
 46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 42 AND 43 - SEE INSTRUCTIONS)

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
	1	2	3	4	5
47 OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)					
48 OVERTIME RATE (SEE INSTRUCTIONS)					
CALCULATION OF LIMIT					
49 TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE)(MULTIPLY LINE 47 TIMES LINE 48)					
50 PERCENTAGE OF OVERTIME HOURS BY CATEGORY (DIVIDE THE HOURS IN EACH COLUMN ON LINE 47 BY THE TOTAL OVERTIME WORKED - COLUMN 5, LINE 47)	100.00				100.00
51 ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL-TIME EMPLOYEE TIME THE PERCENTAGES ON LINE 50 (SEE INSTRUCTIONS)					
DETERMINATION OF OVERTIME ALLOWANCE					
52 ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (SEE INSTRUCTIONS)					
53 OVERTIME COST LIMITATION (LINE 51 TIMES LINE 52)					
54 MAXIMUM OVERTIME COST (ENTER THE LESSOR OF LINE 49 OR LINE 53)					
55 PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (MULTIPLY LINE 47 TIMES LINE 52)					
56 OVERTIME ALLOWANCE (LINE 54 MINUS LINE 55 - IF NEGATIVE ENTER ZERO)(ENTER IN COLUMN 5 THE SUM OF COLUMNS 1, 3, AND 4 FOR RESPIRATORY THERAPY AND COLUMNS 1 THROUGH 3 FOR ALL OTHERS.)					

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 49,680  
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 3,062  
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)  
 60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)  
 61 EQUIPMENT COST (SEE INSTRUCTIONS)  
 62 SUPPLIES (SEE INSTRUCTIONS)  
 63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 52,742  
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 25,555

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

I PROVIDER NO: I 15-1306 I

I PERIOD: I FROM 1/ 1/2010 I TO 12/31/2010 I

I PREPARED 5/30/2011 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66 COST OF OUTSIDE SUPPLIER SERVICES - 25,555

(SEE INSTRUCTIONS)(FROM YOUR RECORDS)

66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I

(SEE INSTRUCTIONS)(FROM YOUR RECORDS)

66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I

(SEE INSTRUCTIONS)(FROM YOUR RECORDS)

67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64) 25,555

68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67) 1.000000

68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)

68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)

69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)

69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)

69.31 EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)

70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/30/2011  
 I 15-1306 I FROM 1/ 1/2010 I NOT A CMS WORKSHEET  
 I I TO 12/31/2010 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
	NEW CAP REL COSTS-MVBLE EQUIP	4	SQUARE	FEET	ENTERED
	EMPLOYEE BENEFITS	5	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	7	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	9	SQUARE	FEET	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	11	MAN	HOURS	ENTERED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED	REQUIS.	ENTERED
16	PHARMACY	15	COSTED	REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	GROSS	REVENUE	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
	0	3	4	5	5a.00	6	8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	568,315	568,315					
005 NEW CAP REL COSTS-MVBLE E	1,364,030		1,364,030				
006 EMPLOYEE BENEFITS	3,493,379	4,139	9,652	3,507,170			
008 ADMINISTRATIVE & GENERAL	4,285,914	67,934	158,403	510,777	5,023,028	5,023,028	
008 OPERATION OF PLANT	992,253	44,104	102,840	57,755	1,196,952	349,707	1,546,659
009 LAUNDRY & LINEN SERVICE	91,533	3,081	7,185		101,799	29,742	11,393
010 HOUSEKEEPING	228,783	7,899	18,417	56,547	311,646	91,052	29,204
011 DIETARY	100,599	16,136	37,625	19,478	173,838	50,789	59,661
012 CAFETERIA	180,284	10,323	24,069	40,528	255,204	74,562	38,166
014 NURSING ADMINISTRATION	522,058	2,065	4,814	173,550	702,487	205,242	7,633
015 CENTRAL SERVICES & SUPPLY	87,397	21,056	49,097	16,475	174,025	50,844	77,851
016 PHARMACY	287,172	12,007	27,997	91,965	419,141	122,458	44,394
017 MEDICAL RECORDS & LIBRARY	418,881	12,839	29,937	100,602	562,259	164,272	47,470
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	1,045,769	77,404	180,485	336,274	1,639,932	479,131	286,189
033 NURSERY	91,465	2,568	5,987	29,488	129,508	37,838	9,494
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	841,673	61,565	143,554	205,249	1,252,041	365,803	227,630
039 DELIVERY ROOM & LABOR ROO	120,199	4,478	10,442	38,751	173,870	50,799	16,558
041 RADIOLOGY-DIAGNOSTIC	1,180,950	61,185	142,668	216,213	1,601,016	467,761	226,225
044 LABORATORY	1,320,150	18,468	43,062	234,459	1,616,139	472,179	68,281
048 INTRAVENOUS THERAPY	120,623	4,211	9,819	16,183	150,836	44,069	15,570
049 RESPIRATORY THERAPY	180,250	2,917	6,802	60,201	250,170	73,091	10,785
050 PHYSICAL THERAPY	378,569	25,606	59,707	122,999	586,881	171,466	7,557
055 MEDICAL SUPPLIES CHARGED	356,219				356,219	104,075	
055 30 IMPL. DEV. CHARGED TO PAT	17,410				17,410	5,087	
056 DRUGS CHARGED TO PATIENTS	1,138,220				1,138,220	332,548	
059 ACUPUNCTURE							
059 97 CARDIAC REHABILITATION	66,174	9,871	23,016	19,832	118,893	34,736	36,495
061 OUTPAT SERVICE COST CNTRS							
061 EMERGENCY	1,373,706	41,650	97,116	769,011	2,281,483	666,568	153,994
062 OBSERVATION BEDS (NON-DIS							
062 OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES	920,961	25,750	119,533	274,875	1,341,119	391,828	89,966
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	21,772,936	537,256	1,312,227	3,391,212	21,574,116	4,835,647	1,464,516
100 NONREIMBURS COST CENTERS							
100 FOUNDATION	36,757	1,797	4,191	11,775	54,520	15,929	6,646
01 OUTREACH	207,254	8,843		56,484	272,581	79,639	
02 SPRING VALLEY FAMILY PRAC	40,290				40,290	11,771	
100 03 PAOLI FAMILY PRACTICE	9,540				9,540	2,787	
100 04 VISITING SPECIALIST CLINI	148,691	20,419	47,612	47,699	264,421	77,255	75,497
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	22,215,468	568,315	1,364,030	3,507,170	22,215,468	5,023,028	1,546,659

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY
	9	10	11	12	14	15	16
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE	142,934						
011 HOUSEKEEPING		431,902					
012 DIETARY		17,077	301,365				
014 CAFETERIA		10,925		378,857			
015 NURSING ADMINISTRATION		2,185		18,614	936,161		
016 CENTRAL SERVICES & SUPPLY				6,421		309,141	
017 PHARMACY				13,153			599,146
025 MEDICAL RECORDS & LIBRARY		13,588		20,782			
033 INPAT ROUTINE SRVC CNTRS							
037 ADULTS & PEDIATRICS	63,418	81,921	301,365	62,272	328,841		
039 NURSERY	442	2,718		3,978	21,007		
041 ANCILLARY SRVC COST CNTRS							
044 OPERATING ROOM		65,157		18,294	96,604		
048 DELIVERY ROOM & LABOR ROO	584	4,739		5,228	27,609		
055 RADIOLOGY-DIAGNOSTIC	19,641	64,755		31,003			
059 LABORATORY		19,545		44,046			
061 INTRAVENOUS THERAPY		4,457		2,651	14,000		30,506
062 RESPIRATORY THERAPY		3,087		10,297			
065 PHYSICAL THERAPY	6,094	27,100		18,980			
095 MEDICAL SUPPLIES CHARGED						309,141	
100 30 IMPL. DEV. CHARGED TO PAT							
101 DRUGS CHARGED TO PATIENTS							568,640
102 ACUPUNCTURE							
103 97 CARDIAC REHABILITATION		10,446		3,078			
061 OUTPAT SERVICE COST CNTRS							
062 EMERGENCY	33,180	44,079		72,710	383,963		
065 OBSERVATION BEDS (NON-DIS							
095 OTHER REIMBURS COST CNTRS							
100 AMBULANCE SERVICES	13,064	27,252		25,961			
101 SPEC PURPOSE COST CENTERS							
102 SUBTOTALS	136,423	399,031	301,365	357,468	872,024	309,141	599,146
103 NONREIMBURS COST CENTERS							
100 FOUNDATION		1,902		1,822			
101 OUTREACH		9,359		7,421			
100 02 SPRING VALLEY FAMILY PRAC							
100 03 PAOLI FAMILY PRACTICE							
101 04 VISITING SPECIALIST CLINI	6,511	21,610		12,146	64,137		
102 CROSS FOOT ADJUSTMENT							
103 NEGATIVE COST CENTER							
103 TOTAL	142,934	431,902	301,365	378,857	936,161	309,141	599,146

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	17	25	26	27
003 GENERAL SERVICE COST CNTR				
004 NEW CAP REL COSTS-BLDG &				
005 NEW CAP REL COSTS-MVBLE E				
006 EMPLOYEE BENEFITS				
008 ADMINISTRATIVE & GENERAL				
009 OPERATION OF PLANT				
010 LAUNDRY & LINEN SERVICE				
011 HOUSEKEEPING				
012 DIETARY				
014 CAFETERIA				
015 NURSING ADMINISTRATION				
016 CENTRAL SERVICES & SUPPLY				
017 PHARMACY				
017 MEDICAL RECORDS & LIBRARY	808,371			
025 INPAT ROUTINE SRVC CNTRS				
033 ADULTS & PEDIATRICS	29,145	3,272,214		3,272,214
033 NURSERY	2,518	207,503		207,503
037 ANCILLARY SRVC COST CNTRS				
039 OPERATING ROOM	73,650	2,099,179		2,099,179
041 DELIVERY ROOM & LABOR ROO	7,813	287,200		287,200
044 RADIOLOGY-DIAGNOSTIC	210,421	2,620,822		2,620,822
048 LABORATORY	120,954	2,341,144		2,341,144
049 INTRAVENOUS THERAPY	14,825	276,914		276,914
050 RESPIRATORY THERAPY	7,622	355,052		355,052
055 PHYSICAL THERAPY	28,495	846,573		846,573
055 MEDICAL SUPPLIES CHARGED	18,468	787,903		787,903
059 30 IMPL. DEV. CHARGED TO PAT	1,122	23,619		23,619
059 DRUGS CHARGED TO PATIENTS	116,374	2,155,782		2,155,782
059 ACUPUNCTURE				
059 97 CARDIAC REHABILITATION	1,690	205,338		205,338
061 OUTPAT SERVICE COST CNTRS				
062 EMERGENCY	125,809	3,761,786		3,761,786
065 OBSERVATION BEDS (NON-DIS				
065 OTHER REIMBURS COST CNTRS				
065 AMBULANCE SERVICES	49,465	1,938,655		1,938,655
095 SPEC PURPOSE COST CENTERS				
095 SUBTOTALS	808,371	21,179,684		21,179,684
100 NONREIMBURS COST CENTERS				
100 FOUNDATION		80,819		80,819
100 01 OUTREACH		369,000		369,000
100 02 SPRING VALLEY FAMILY PRAC		52,061		52,061
100 03 PAOLI FAMILY PRACTICE		12,327		12,327
100 04 VISITING SPECIALIST CLINI		521,577		521,577
101 CROSS FOOT ADJUSTMENT				
102 NEGATIVE COST CENTER				
103 TOTAL	808,371	22,215,468		22,215,468

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/30/2011  
 I 15-1306 I FROM 1/ 1/2010 I WORKSHEET B  
 I I TO 12/31/2010 I PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	NEW CAP REL COSTS-BLDG & OSTS	NEW CAP REL COSTS-MVBLE & E	SUBTOTAL	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT
	0	3	4	4a	5	6	8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS		4,139	9,652	13,791	13,791		
006 ADMINISTRATIVE & GENERAL		67,934	158,403	226,337	2,008	228,345	
008 OPERATION OF PLANT		44,104	102,840	146,944	227	15,898	163,069
009 LAUNDRY & LINEN SERVICE		3,081	7,185	10,266		1,352	1,201
010 HOUSEKEEPING		7,899	18,417	26,316	222	4,139	3,079
011 DIETARY		16,136	37,625	53,761	77	2,309	6,290
012 CAFETERIA		10,323	24,069	34,392	159	3,390	4,024
014 NURSING ADMINISTRATION		2,065	4,814	6,879	682	9,330	805
015 CENTRAL SERVICES & SUPPLY		21,056	49,097	70,153	65	2,311	8,208
016 PHARMACY		12,007	27,997	40,004	362	5,567	4,681
017 MEDICAL RECORDS & LIBRARY		12,839	29,937	42,776	395	7,468	5,005
025 INPAT ROUTINE SRVC CNTRS							
033 ADULTS & PEDIATRICS		77,404	180,485	257,889	1,322	21,782	30,172
033 NURSERY		2,568	5,987	8,555	116	1,720	1,001
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		61,565	143,554	205,119	807	16,630	24,000
039 DELIVERY ROOM & LABOR ROO		4,478	10,442	14,920	152	2,309	1,746
041 RADIOLOGY-DIAGNOSTIC		61,185	142,668	203,853	850	21,265	23,852
044 LABORATORY		18,468	43,062	61,530	922	21,466	7,199
048 INTRAVENOUS THERAPY		4,211	9,819	14,030	64	2,003	1,642
049 RESPIRATORY THERAPY		2,917	6,802	9,719	237	3,323	1,137
050 PHYSICAL THERAPY		25,606	59,707	85,313	484	7,795	797
055 MEDICAL SUPPLIES CHARGED						4,731	
055 30 IMPL. DEV. CHARGED TO PAT						231	
056 DRUGS CHARGED TO PATIENTS						15,118	
059 ACUPUNCTURE							
059 97 CARDIAC REHABILITATION		9,871	23,016	32,887	78	1,579	3,848
061 OUTPAT SERVICE COST CNTRS							
061 EMERGENCY		41,650	97,116	138,766	3,025	30,298	16,236
062 OBSERVATION BEDS (NON-DIS							
062 OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES	7,288	25,750	119,533	152,571	1,081	17,813	9,485
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	7,288	537,256	1,312,227	1,856,771	13,335	219,827	154,408
100 NONREIMBURS COST CENTERS							
100 FOUNDATION		1,797	4,191	5,988	46	724	701
01 OUTREACH		8,843		8,843	222	3,620	
02 SPRING VALLEY FAMILY PRAC	9,582			9,582		535	
100 03 PAOLI FAMILY PRACTICE	4,191			4,191		127	
100 04 VISITING SPECIALIST CLINI		20,419	47,612	68,031	188	3,512	7,960
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	21,061	568,315	1,364,030	1,953,406	13,791	228,345	163,069

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	CENTRAL SERVI CES & SUPPLY	PHARMACY
	9	10	11	12	14	15	16
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE	12,819						
011 HOUSEKEEPING		33,756					
012 DIETARY		1,335	63,772				
014 CAFETERIA		854		42,819			
015 NURSING ADMINISTRATION		171		2,104	19,971		
016 CENTRAL SERVICES & SUPPLY				726		81,463	
017 PHARMACY				1,487			52,101
017 MEDICAL RECORDS & LIBRARY		1,062		2,349			
025 INPAT ROUTINE SRVC CNTRS							
033 ADULTS & PEDIATRICS	5,686	6,404	63,772	7,038	7,015		
037 NURSERY	40	212		450	448		
037 ANCILLARY SRVC COST CNTRS							
039 OPERATING ROOM		5,092		2,068	2,061		
041 DELIVERY ROOM & LABOR ROO	52	370		591	589		
044 RADIOLOGY-DIAGNOSTIC	1,762	5,061		3,504			
048 LABORATORY		1,528		4,978			
049 INTRAVENOUS THERAPY		348		300	299		2,653
050 RESPIRATORY THERAPY		241		1,164			
055 PHYSICAL THERAPY	547	2,118		2,145			
055 MEDICAL SUPPLIES CHARGED						81,463	
056 30 IMPL. DEV. CHARGED TO PAT							
059 DRUGS CHARGED TO PATIENTS							49,448
059 ACUPUNCTURE							
059 97 CARDIAC REHABILITATION		816		348			
061 OUTPAT SERVICE COST CNTRS							
062 EMERGENCY	2,976	3,445		8,215	8,191		
065 OBSERVATION BEDS (NON-DIS							
065 OTHER REIMBURS COST CNTRS	1,172	2,130		2,934			
095 SPEC PURPOSE COST CENTERS							
100 SUBTOTALS	12,235	31,187	63,772	40,401	18,603	81,463	52,101
100 NONREIMBURS COST CENTERS							
100 FOUNDATION		149		206			
100 01 OUTREACH		731		839			
100 02 SPRING VALLEY FAMILY PRAC							
100 03 PAOLI FAMILY PRACTICE							
100 04 VISITING SPECIALIST CLINI	584	1,689		1,373	1,368		
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	12,819	33,756	63,772	42,819	19,971	81,463	52,101

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	17	25	26	27
003 GENERAL SERVICE COST CNTR				
004 NEW CAP REL COSTS-BLDG &				
005 NEW CAP REL COSTS-MVBLE E				
006 EMPLOYEE BENEFITS				
008 ADMINISTRATIVE & GENERAL				
009 OPERATION OF PLANT				
010 LAUNDRY & LINEN SERVICE				
011 HOUSEKEEPING				
012 DIETARY				
014 CAFETERIA				
015 NURSING ADMINISTRATION				
016 CENTRAL SERVICES & SUPPLY				
017 PHARMACY				
017 MEDICAL RECORDS & LIBRARY	59,055			
025 INPAT ROUTINE SRVC CNTRS				
033 ADULTS & PEDIATRICS	2,130	403,210		403,210
037 NURSERY	184	12,726		12,726
037 ANCILLARY SRVC COST CNTRS				
039 OPERATING ROOM	5,381	261,158		261,158
041 DELIVERY ROOM & LABOR ROO	571	21,300		21,300
044 RADIOLOGY-DIAGNOSTIC	15,366	275,513		275,513
048 LABORATORY	8,838	106,461		106,461
049 INTRAVENOUS THERAPY	1,083	22,422		22,422
050 RESPIRATORY THERAPY	557	16,378		16,378
055 PHYSICAL THERAPY	2,082	101,281		101,281
055 MEDICAL SUPPLIES CHARGED	1,349	87,543		87,543
055 30 IMPL. DEV. CHARGED TO PAT	82	313		313
056 DRUGS CHARGED TO PATIENTS	8,503	73,069		73,069
059 ACUPUNCTURE				
059 97 CARDIAC REHABILITATION	123	39,679		39,679
061 OUTPAT SERVICE COST CNTRS				
062 EMERGENCY	9,192	220,344		220,344
065 OBSERVATION BEDS (NON-DIS				
065 OTHER REIMBURS COST CNTRS				
095 AMBULANCE SERVICES	3,614	190,800		190,800
095 SPEC PURPOSE COST CENTERS				
095 SUBTOTALS	59,055	1,832,197		1,832,197
100 NONREIMBURS COST CENTERS				
100 FOUNDATION		7,814		7,814
100 01 OUTREACH		14,255		14,255
100 02 SPRING VALLEY FAMILY PRAC		10,117		10,117
100 03 PAOLI FAMILY PRACTICE		4,318		4,318
100 04 VISITING SPECIALIST CLINI		84,705		84,705
101 CROSS FOOT ADJUSTMENTS				
102 NEGATIVE COST CENTER				
103 TOTAL	59,055	1,953,406		1,953,406

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO:  
I 15-1306  
I

I PERIOD:  
I FROM 1/ 1/2010  
I TO 12/31/2010 I

I PREPARED 5/30/2011  
I WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	S RECONCIL- ) IATION	ADMINISTRATIV	OPERATION OF
	OSTS-BLDG &	OSTS-MVBLE E	FITS		E & GENERAL	PLANT
	(SQUARE FEET	(SQUARE ) FEET	(GROSS )ALARIES		( ACCUM. COST	(SQUARE ) FEET
	3	4	5	6a.00	6	8
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	55,331					
005 NEW CAP REL COSTS-MVB		56,954				
006 EMPLOYEE BENEFITS	403	403	10,189,701			
008 ADMINISTRATIVE & GENE	6,614	6,614	1,484,007	-5,023,028	17,192,440	
009 OPERATION OF PLANT	4,294	4,294	167,800		1,196,952	40,727
010 LAUNDRY & LINEN SERVI	300	300			101,799	300
011 HOUSEKEEPING	769	769	164,291		311,646	769
012 DIETARY	1,571	1,571	56,592		173,838	1,571
014 CAFETERIA	1,005	1,005	117,751		255,204	1,005
015 NURSING ADMINISTRATIO	201	201	504,231		702,487	201
016 CENTRAL SERVICES & SU	2,050	2,050	47,867		174,025	2,050
017 PHARMACY	1,169	1,169	267,195		419,141	1,169
025 MEDICAL RECORDS & LIB	1,250	1,250	292,287		562,259	1,250
033 INPAT ROUTINE SRVC CN						
ADULTS & PEDIATRICS	7,536	7,536	977,008		1,639,932	7,536
NURSERY	250	250	85,673		129,508	250
ANCILLARY SRVC COST C						
037 OPERATING ROOM	5,994	5,994	596,328		1,252,041	5,994
039 DELIVERY ROOM & LABOR	436	436	112,587		173,870	436
041 RADIOLOGY-DIAGNOSTIC	5,957	5,957	628,184		1,601,016	5,957
044 LABORATORY	1,798	1,798	681,195		1,616,139	1,798
048 INTRAVENOUS THERAPY	410	410	47,017		150,836	410
049 RESPIRATORY THERAPY	284	284	174,907		250,170	284
050 PHYSICAL THERAPY	2,493	2,493	357,360		586,881	199
055 MEDICAL SUPPLIES CHAR					356,219	
055 30 IMPL. DEV. CHARGED TO					17,410	
056 DRUGS CHARGED TO PATI					1,138,220	
059 ACUPUNCTURE						
059 97 CARDIAC REHABILITATIO	961	961	57,621		118,893	961
061 OUTPAT SERVICE COST C						
EMERGENCY	4,055	4,055	2,234,276		2,281,483	4,055
062 OBSERVATION BEDS (NON						
OTHER REIMBURS COST C						
065 AMBULANCE SERVICES	2,507	4,991	798,618		1,341,119	2,369
SPEC PURPOSE COST CEN						
065 SUBTOTALS	52,307	54,791	9,852,795	-5,023,028	16,551,088	38,564
NONREIMBURS COST CENT						
100 FOUNDATION	175	175	34,212		54,520	175
100 01 OUTREACH	861		164,109		272,581	
100 02 SPRING VALLEY FAMILY					40,290	
100 03 PAOLI FAMILY PRACTICE					9,540	
100 04 VISITING SPECIALIST C	1,988	1,988	138,585		264,421	1,988
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	568,315	1,364,030	3,507,170		5,023,028	1,546,659
(WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	10.271186		.344188		.292165	
(WRKSHT B, PT I)		23.949679				37.976257
105 COST TO BE ALLOCATED						
(WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
(WRKSHT B, PT II)						
107 COST TO BE ALLOCATED			13,791		228,345	163,069
(WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER			.001353		.013282	4.003953
(WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	R )
		(POUNDS OF LAUNDRY)	(SQUARE FEET)	(MEALS SERVED)	S(MAN) HOURS	(DIRECT)SING HRS	NR(COSTED)EQUIS.	R(COSTED)EQUIS.	
		9	10	11	12	14	15	16	
	GENERAL SERVICE COST								
003	NEW CAP REL COSTS-BLD								
004	NEW CAP REL COSTS-MVB								
005	EMPLOYEE BENEFITS								
006	ADMINISTRATIVE & GENE								
008	OPERATION OF PLANT								
009	LAUNDRY & LINEN SERVI	17,145							
010	HOUSEKEEPING		39,732						
011	DIETARY		1,571	7,460					
012	CAFETERIA		1,005		251,228				
014	NURSING ADMINISTRATIO		201			117,558			
015	CENTRAL SERVICES & SU						100		
016	PHARMACY							1,161,317	
017	MEDICAL RECORDS & LIB		1,250		13,781				
025	INPAT ROUTINE SRVC CN								
025	ADULTS & PEDIATRICS	7,607	7,536	7,460	41,294	41,294			
033	NURSERY	53	250		2,638	2,638			
	ANCILLARY SRVC COST C								
037	OPERATING ROOM		5,994		12,131	12,131			
039	DELIVERY ROOM & LABOR	70	436		3,467	3,467			
041	RADIOLOGY-DIAGNOSTIC	2,356	5,957		20,559				
044	LABORATORY		1,798		29,208				
048	INTRAVENOUS THERAPY		410		1,758	1,758		59,130	
049	RESPIRATORY THERAPY		284		6,828				
050	PHYSICAL THERAPY	731	2,493		12,586				
055	MEDICAL SUPPLIES CHAR						100		
055	30 IMPL. DEV. CHARGED TO								
056	DRUGS CHARGED TO PATI							1,102,187	
059	ACUPUNCTURE								
059	97 CARDIAC REHABILITATIO		961		2,041				
	OUTPAT SERVICE COST C								
061	EMERGENCY	3,980	4,055		48,216	48,216			
062	OBSERVATION BEDS (NON								
	OTHER REIMBURS COST C								
065	AMBULANCE SERVICES	1,567	2,507		17,215				
	SPEC PURPOSE COST CEN								
	SUBTOTALS	16,364	36,708	7,460	237,045	109,504	100	1,161,317	
	NONREIMBURS COST CENT								
100	FOUNDATION		175		1,208				
100	01 OUTREACH		861		4,921				
100	02 SPRING VALLEY FAMILY								
100	03 PAOLI FAMILY PRACTICE								
100	04 VISITING SPECIALIST C	781	1,988		8,054	8,054			
101	CROSS FOOT ADJUSTMENT								
102	NEGATIVE COST CENTER								
103	COST TO BE ALLOCATED	142,934	431,902	301,365	378,857	936,161	309,141	599,146	
	(WRKSHT B, PART I)								
104	UNIT COST MULTIPLIER		10.870382	40.397453	1.508021	7.963397	3,091.410000	.515919	
	(WRKSHT B, PT I)	8.336775							
105	COST TO BE ALLOCATED								
	(WRKSHT B, PART II)								
106	UNIT COST MULTIPLIER								
	(WRKSHT B, PT II)								
107	COST TO BE ALLOCATED	12,819	33,756	63,772	42,819	19,971	81,463	52,101	
	(WRKSHT B, PART III)								
108	UNIT COST MULTIPLIER		.849592	8.548525	.170439	.169882	814.630000	.044864	
	(WRKSHT B, PT III)	.747682							

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	(GROSS REVENUE )
		17
003 GENERAL SERVICE COST		
004 NEW CAP REL COSTS-BLD		
005 NEW CAP REL COSTS-MVB		
006 EMPLOYEE BENEFITS		
008 ADMINISTRATIVE & GENE		
009 OPERATION OF PLANT		
010 LAUNDRY & LINEN SERVI		
011 HOUSEKEEPING		
012 DIETARY		
014 CAFETERIA		
015 NURSING ADMINISTRATIO		
016 CENTRAL SERVICES & SU		
017 PHARMACY		
025 MEDICAL RECORDS & LIB	47,024,690	
033 INPAT ROUTINE SRVC CN		
037 ADULTS & PEDIATRICS	1,695,472	
039 NURSERY	146,502	
041 ANCILLARY SRVC COST C		
044 OPERATING ROOM	4,284,484	
048 DELIVERY ROOM & LABOR	454,523	
050 RADIOLOGY-DIAGNOSTIC	12,239,804	
055 LABORATORY	7,036,319	
059 INTRAVENOUS THERAPY	862,442	
061 RESPIRATORY THERAPY	443,378	
062 PHYSICAL THERAPY	1,657,669	
065 MEDICAL SUPPLIES CHAR	1,074,339	
066 30 IMPL. DEV. CHARGED TO	65,257	
067 056 DRUGS CHARGED TO PATI	6,769,892	
068 059 ACUPUNCTURE		
069 97 CARDIAC REHABILITATIO	98,313	
070 061 OUTPAT SERVICE COST C		
071 062 EMERGENCY	7,318,751	
072 065 OBSERVATION BEDS (NON		
073 066 OTHER REIMBURS COST C		
074 067 AMBULANCE SERVICES	2,877,545	
075 068 SPEC PURPOSE COST CEN		
076 069 SUBTOTALS	47,024,690	
077 100 NONREIMBURS COST CENT		
078 100 FOUNDATION		
079 100 01 OUTREACH		
080 100 02 SPRING VALLEY FAMILY		
081 100 03 PAOLI FAMILY PRACTICE		
082 100 04 VISITING SPECIALIST C		
083 101 CROSS FOOT ADJUSTMENT		
084 102 NEGATIVE COST CENTER		
085 103 COST TO BE ALLOCATED	808,371	
086 104 (PER WRKSHT B, PART		
087 104 UNIT COST MULTIPLIER		
088 105 (WRKSHT B, PT I)	.017190	
089 105 COST TO BE ALLOCATED		
090 106 (PER WRKSHT B, PART		
091 106 UNIT COST MULTIPLIER		
092 107 (WRKSHT B, PT II)	59,055	
093 107 COST TO BE ALLOCATED		
094 108 (PER WRKSHT B, PART		
095 108 UNIT COST MULTIPLIER	.001256	
096 108 (WRKSHT B, PT III)		

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
33	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	3,272,214		3,272,214		3,272,214
	NURSERY	207,503		207,503		207,503
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	2,099,179		2,099,179		2,099,179
39	DELIVERY ROOM & LABOR ROO	287,200		287,200		287,200
41	RADIOLOGY-DIAGNOSTIC	2,620,822		2,620,822		2,620,822
44	LABORATORY	2,341,144		2,341,144		2,341,144
48	INTRAVENOUS THERAPY	276,914		276,914		276,914
49	RESPIRATORY THERAPY	355,052		355,052		355,052
50	PHYSICAL THERAPY	846,573		846,573		846,573
55	MEDICAL SUPPLIES CHARGED	787,903		787,903		787,903
55	30 IMPL. DEV. CHARGED TO PAT	23,619		23,619		23,619
56	DRUGS CHARGED TO PATIENTS	2,155,782		2,155,782		2,155,782
59	ACUPUNCTURE					
59	97 CARDIAC REHABILITATION	205,338		205,338		205,338
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	3,761,786		3,761,786		3,761,786
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	1,617,993		1,617,993		1,617,993
65	AMBULANCE SERVICES	1,938,655		1,938,655		1,938,655
101	SUBTOTAL	22,797,677		22,797,677		22,797,677
102	LESS OBSERVATION BEDS	1,617,993		1,617,993		1,617,993
103	TOTAL	21,179,684		21,179,684		21,179,684

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
33	ADULTS & PEDIATRICS	845,620		845,620			
	NURSERY	146,502		146,502			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	555,444	3,729,040	4,284,484	.489949	.489949	.489949
39	DELIVERY ROOM & LABOR ROO	320,964	133,560	454,524	.631870	.631870	.631870
41	RADIOLOGY-DIAGNOSTIC	87,392	12,152,412	12,239,804	.214123	.214123	.214123
44	LABORATORY	474,298	6,562,020	7,036,318	.332723	.332723	.332723
48	INTRAVENOUS THERAPY	215,838	646,605	862,443	.321081	.321081	.321081
49	RESPIRATORY THERAPY	89,021	354,356	443,377	.800790	.800790	.800790
50	PHYSICAL THERAPY	127,477	1,530,193	1,657,670	.510701	.510701	.510701
55	MEDICAL SUPPLIES CHARGED	307,394	766,945	1,074,339	.733384	.733384	.733384
55 30	IMPL. DEV. CHARGED TO PAT		65,257	65,257	.361938	.361938	.361938
56	DRUGS CHARGED TO PATIENTS	699,767	6,070,123	6,769,890	.318437	.318437	.318437
59	ACUPUNCTURE						
59 97	CARDIAC REHABILITATION		98,313	98,313	2.088615	2.088615	2.088615
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	231,161	7,087,591	7,318,752	.513993	.513993	.513993
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS		849,852	849,852	1.903853	1.903853	1.903853
65	AMBULANCE SERVICES		2,877,545	2,877,545	.673718	.673718	.673718
101	SUBTOTAL	4,100,878	42,923,812	47,024,690			
102	LESS OBSERVATION BEDS						
103	TOTAL	4,100,878	42,923,812	47,024,690			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	2,099,179	261,158	1,838,021			2,099,179
39	DELIVERY ROOM & LABOR ROO	287,200	21,300	265,900			287,200
41	RADIOLOGY-DIAGNOSTIC	2,620,822	275,513	2,345,309			2,620,822
44	LABORATORY	2,341,144	106,461	2,234,683			2,341,144
48	INTRAVENOUS THERAPY	276,914	22,422	254,492			276,914
49	RESPIRATORY THERAPY	355,052	16,378	338,674			355,052
50	PHYSICAL THERAPY	846,573	101,281	745,292			846,573
55	MEDICAL SUPPLIES CHARGED	787,903	87,543	700,360			787,903
55	30 IMPL. DEV. CHARGED TO PAT	23,619	313	23,306			23,619
56	DRUGS CHARGED TO PATIENTS	2,155,782	73,069	2,082,713			2,155,782
59	ACUPUNCTURE						
59	97 CARDIAC REHABILITATION	205,338	39,679	165,659			205,338
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	3,761,786	220,344	3,541,442			3,761,786
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	1,617,993		1,617,993			1,617,993
65	AMBULANCE SERVICES	1,938,655	190,800	1,747,855			1,938,655
101	SUBTOTAL	19,317,960	1,416,261	17,901,699			19,317,960
102	LESS OBSERVATION BEDS	1,617,993		1,617,993			1,617,993
103	TOTAL	17,699,967	1,416,261	16,283,706			17,699,967

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	4,284,484	.489949	.489949
39	DELIVERY ROOM & LABOR ROO	454,524	.631870	.631870
41	RADIOLOGY-DIAGNOSTIC	12,239,804	.214123	.214123
44	LABORATORY	7,036,318	.332723	.332723
48	INTRAVENOUS THERAPY	862,443	.321081	.321081
49	RESPIRATORY THERAPY	443,377	.800790	.800790
50	PHYSICAL THERAPY	1,657,670	.510701	.510701
55	MEDICAL SUPPLIES CHARGED	1,074,339	.733384	.733384
55	30 IMPL. DEV. CHARGED TO PAT	65,257	.361938	.361938
56	DRUGS CHARGED TO PATIENTS	6,769,890	.318437	.318437
59	ACUPUNCTURE			
59	97 CARDIAC REHABILITATION	98,313	2.088615	2.088615
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	7,318,752	.513993	.513993
62	OBSERVATION BEDS (NON-DIS	849,852	1.903853	1.903853
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	2,877,545	.673718	.673718
101	SUBTOTAL	46,032,568		
102	LESS OBSERVATION BEDS	849,852		
103	TOTAL	45,182,716		

WVST A NO.	COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
		CAPITAL REL COST (B, II) 1	SWING BED ADJUSTMENT 2	REDUCED CAP RELATED COST 3	CAPITAL REL COST (B, III) 4	SWING BED ADJUSTMENT 5	REDUCED CAP RELATED COST 6
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS				403,210	27,819	375,391
33	NURSERY				12,726		12,726
101	TOTAL				415,936		388,117

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	INPAT PROGRAM OLD CAP CST 10	NEW CAPITAL PER DIEM 11	INPAT PROGRAM NEW CAP CST 12
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,186	233			171.73	40,013
33	NURSERY	244	182			52.16	9,493
101	TOTAL	2,430	415				49,506

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/30/2011  
 I 15-1306 I FROM 1/ 1/2010 I WORKSHEET D  
 I COMPONENT NO: I TO 12/31/2010 I PART II  
 I 15-1306 I I

TITLE XIX

HOSPITAL

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	CST/CHRG RATIO 5	OLD CAPITAL COSTS 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM		261,158	4,284,484	330,416		
39	DELIVERY ROOM & LABOR ROO		21,300	454,524	304,371		
41	RADIOLOGY-DIAGNOSTIC		275,513	12,239,804	15,638		
44	LABORATORY		106,461	7,036,318	126,543		
48	INTRAVENOUS THERAPY		22,422	862,443	26,149		
49	RESPIRATORY THERAPY		16,378	443,377	35,807		
50	PHYSICAL THERAPY		101,281	1,657,670	1,812		
55	MEDICAL SUPPLIES CHARGED		87,543	1,074,339	16,393		
55	30 IMPL. DEV. CHARGED TO PAT		313	65,257			
56	DRUGS CHARGED TO PATIENTS		73,069	6,769,890	179,459		
59	ACUPUNCTURE						
59	97 CARDIAC REHABILITATION		39,679	98,313			
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY		220,344	7,318,752	18,358		
62	OBSERVATION BEDS (NON-DIS			849,852			
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
101	TOTAL		1,225,461	43,155,023	1,054,946		

TITLE XIX		HOSPITAL	
WKST A	COST CENTER DESCRIPTION	NEW CAPITAL	
LINE NO.		CST/CHRG RATIO	COSTS
		7	8
	ANCILLARY SRVC COST CNTRS		
37	OPERATING ROOM	.060954	20,140
39	DELIVERY ROOM & LABOR ROO	.046862	14,263
41	RADIOLOGY-DIAGNOSTIC	.022510	352
44	LABORATORY	.015130	1,915
48	INTRAVENOUS THERAPY	.025998	680
49	RESPIRATORY THERAPY	.036939	1,323
50	PHYSICAL THERAPY	.061098	111
55	MEDICAL SUPPLIES CHARGED	.081485	1,336
55	30 IMPL. DEV. CHARGED TO PAT	.004796	
56	DRUGS CHARGED TO PATIENTS	.010793	1,937
59	ACUPUNCTURE		
59	97 CARDIAC REHABILITATION	.403599	
	OUTPAT SERVICE COST CNTRS		
61	EMERGENCY	.030107	553
62	OBSERVATION BEDS (NON-DIS		
	OTHER REIMBURS COST CNTRS		
65	AMBULANCE SERVICES		
101	TOTAL		42,610

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST	MED EDUCATN COST	SWING BED ADJ AMOUNT	TOTAL COSTS	TOTAL PATIENT DAYS	PER DIEM
		1	2	3	4	5	6
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS					2,186	
33	NURSERY					244	
101	TOTAL					2,430	

WKST A LT'S NO.	COST CENTER DESCRIPTION	INPATIENT PROG DAYS	INPAT PROGRAM PASS THRU COST
		7	8
33	ADULTS & PEDIATRICS	233	
101	NURSERY	182	
	TOTAL	415	

TITLE XIX

HOSPITAL

PPS

WKST A LT'S NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST		MED ED NRS SCHOOL COST	MED ED ALLIED HEALTH COST	MED ED ALL OTHER COSTS	BLOOD CLOT FOR HEMOPHILIACS
		1	1.01	2	2.01	2.02	2.03
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
39	DELIVERY ROOM & LABOR ROO						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
55	MEDICAL SUPPLIES CHARGED						
55 30	IMPL. DEV. CHARGED TO PAT						
56	DRUGS CHARGED TO PATIENTS						
59	ACUPUNCTURE						
59 97	CARDIAC REHABILITATION						
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
101	TOTAL						

TITLE XIX

HOSPITAL

PPS

WKST A LTIME NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM			4,284,484			330,416	
39	DELIVERY ROOM & LABOR ROO			454,524			304,371	
41	RADIOLOGY-DIAGNOSTIC			12,239,804			15,638	
44	LABORATORY			7,036,318			126,543	
48	INTRAVENOUS THERAPY			862,443			26,149	
49	RESPIRATORY THERAPY			443,377			35,807	
50	PHYSICAL THERAPY			1,657,670			1,812	
55	MEDICAL SUPPLIES CHARGED			1,074,339			16,393	
55	30 IMPL. DEV. CHARGED TO PAT			65,257				
56	DRUGS CHARGED TO PATIENTS			6,769,890			179,459	
59	ACUPUNCTURE							
59	97 CARDIAC REHABILITATION			98,313				
	OUTPAT SERVICE COST CNTRS							
61	EMERGENCY			7,318,752			18,358	
62	OBSERVATION BEDS (NON-DIS			849,852				
	OTHER REIMBURS COST CNTRS							
65	AMBULANCE SERVICES							
101	TOTAL			43,155,023			1,054,946	

TITLE XIX

HOSPITAL

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OUTPAT PROG CHARGES 8	OUTPAT PROG D,V COL 5.03 8.01	OUTPAT PROG D,V COL 5.04 8.02	OUTPAT PROG PASS THRU COST 9	COL 8.01 * COL 5 9.01	COL 8.02 * COL 5 9.02
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	471,138					
39	DELIVERY ROOM & LABOR ROO	73,798					
41	RADIOLOGY-DIAGNOSTIC	1,950,392					
44	LABORATORY	969,386					
48	INTRAVENOUS THERAPY	56,173					
49	RESPIRATORY THERAPY	96,682					
50	PHYSICAL THERAPY	344,640					
55	MEDICAL SUPPLIES CHARGED	59,722					
55	30 IMPL. DEV. CHARGED TO PAT						
56	DRUGS CHARGED TO PATIENTS	638,650					
59	ACUPUNCTURE						
59	97 CARDIAC REHABILITATION	322					
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	1,762,912					
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	167,623					
65	AMBULANCE SERVICES	406,648					
101	TOTAL	6,998,086					

TITLE XVIII, PART B HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.489949		.489949		
39 DELIVERY ROOM & LABOR ROOM	.631870		.631870		
41 RADIOLOGY-DIAGNOSTIC	.214123		.214123		
44 LABORATORY	.332723		.332723		
48 INTRAVENOUS THERAPY	.321081		.321081		
49 RESPIRATORY THERAPY	.800790		.800790		
50 PHYSICAL THERAPY	.510701		.510701		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.733384		.733384		
55 30 IMPL. DEV. CHARGED TO PATIENT	.361938		.361938		
56 DRUGS CHARGED TO PATIENTS	.318437		.318437		
59 ACUPUNCTURE					
59 97 CARDIAC REHABILITATION	2.088615		2.088615		
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY	.513993		.513993		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.903853		1.903853		
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES	.673718		.673718		
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS  
 (1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	4	5	6	7	8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		1,140,155			
39 DELIVERY ROOM & LABOR ROOM		210			
41 RADIOLOGY-DIAGNOSTIC		3,276,755			
44 LABORATORY		2,395,809			
48 INTRAVENOUS THERAPY		230,092			
49 RESPIRATORY THERAPY		144,530			
50 PHYSICAL THERAPY		394,457			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		374,853			
55 30 IMPL. DEV. CHARGED TO PATIENT		24,735			
56 DRUGS CHARGED TO PATIENTS		2,130,070			
59 ACUPUNCTURE					
59 97 CARDIAC REHABILITATION		57,269			
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY		1,902,755			
62 OBSERVATION BEDS (NON-DISTINCT PART)		432,896			
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES					
101 SUBTOTAL		12,504,586			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		12,504,586			

(A) WORKSHEET A LINE NUMBERS  
 (1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM	558,618		
39 DELIVERY ROOM & LABOR ROOM	133		
41 RADIOLOGY-DIAGNOSTIC	701,629		
44 LABORATORY	797,141		
48 INTRAVENOUS THERAPY	73,878		
49 RESPIRATORY THERAPY	115,738		
50 PHYSICAL THERAPY	201,450		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	274,911		
55 30 IMPL. DEV. CHARGED TO PATIENT	8,953		
56 DRUGS CHARGED TO PATIENTS	678,293		
59 ACUPUNCTURE			
59 97 CARDIAC REHABILITATION	119,613		
OUTPAT SERVICE COST CNTRS			
61 EMERGENCY	978,003		
62 OBSERVATION BEDS (NON-DISTINCT PART)	824,170		
OTHER REIMBURS COST CNTRS			
65 AMBULANCE SERVICES			
101 SUBTOTAL	5,332,530		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104 NET CHARGES	5,332,530		

(A) WORKSHEET A LINE NUMBERS  
 (1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic	All other (1)
	1	2	3	4	5
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.489949				471,138
39 DELIVERY ROOM & LABOR ROOM	.631870				73,798
41 RADIOLOGY-DIAGNOSTIC	.214123				1,950,392
44 LABORATORY	.332723				969,386
48 INTRAVENOUS THERAPY	.321081				56,173
49 RESPIRATORY THERAPY	.800790				96,682
50 PHYSICAL THERAPY	.510701				344,640
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.733384				59,722
55 30 IMPL. DEV. CHARGED TO PATIENT	.361938				
56 DRUGS CHARGED TO PATIENTS	.318437				638,650
59 ACUPUNCTURE					
59 97 CARDIAC REHABILITATION	2.088615				322
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY	.513993				1,762,912
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.903853				167,623
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES	.673718				406,648
101 SUBTOTAL					6,998,086
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					6,998,086

(A) WORKSHEET A LINE NUMBERS  
 (1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XIX - O/P

HOSPITAL

	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
Cost Center Description	5.01	5.02	5.03	6	7
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM					
39 DELIVERY ROOM & LABOR ROOM					
41 RADIOLOGY-DIAGNOSTIC					
44 LABORATORY					
48 INTRAVENOUS THERAPY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
55 30 IMPL. DEV. CHARGED TO PATIENT					
56 DRUGS CHARGED TO PATIENTS					
59 ACUPUNCTURE					
59 97 CARDIAC REHABILITATION					
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY					
62 OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS  
 (1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
	8	9	9.01	9.02	9.03
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		230,834			
39 DELIVERY ROOM & LABOR ROOM		46,631			
41 RADIOLOGY-DIAGNOSTIC		417,624			
44 LABORATORY		322,537			
48 INTRAVENOUS THERAPY		18,036			
49 RESPIRATORY THERAPY		77,422			
50 PHYSICAL THERAPY		176,008			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		43,799			
55 30 IMPL. DEV. CHARGED TO PATIENT					
56 DRUGS CHARGED TO PATIENTS		203,370			
59 ACUPUNCTURE					
59 97 CARDIAC REHABILITATION		673			
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY		906,124			
62 OBSERVATION BEDS (NON-DISTINCT PART)		319,130			
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES		273,966			
101 SUBTOTAL		3,036,154			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		3,036,154			

(A) WORKSHEET A LINE NUMBERS  
 (1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1	.318437
2	PROGRAM VACCINE CHARGES		733
3	PROGRAM COSTS		233

TITLE XVIII PART A HOSPITAL OTHER

T I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	2,348
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,186
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,186
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	162
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	522
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	145
11	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)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,272,214
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	225,766
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,046,448

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	773,084
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	773,084
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	3.940643
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	353.65
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3,046,448

TITLE XVIII PART A HOSPITAL OTHER

II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE  
 PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM					1,393.62
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					727,470
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					727,470

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)				
	INTENSIVE CARE TYPE INPATIENT				
	HOSPITAL UNITS				
43	INTENSIVE CARE UNIT				
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				
					1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				
49	TOTAL PROGRAM INPATIENT COSTS				

333,031  
 1,060,501

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
52	TOTAL PROGRAM EXCLUDABLE COST
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES
55	TARGET AMOUNT PER DISCHARGE
56	TARGET AMOUNT
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT BONUS PAYMENT
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.
58.04	RELIEF PAYMENT
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1
59.03	PROGRAM DISCHARGES AFTER JULY 1
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	202,075
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	202,075
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

TITLE XVIII PART A HOSPITAL OTHER

PART III - SKILLED NURSING FACILITY, NURSING FACILITY & ICF/MR ONLY

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	
72	PER DIEM CAPITAL-RELATED COSTS	
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	1,161
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,393.62
85	OBSERVATION BED COST	1,617,993

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86	OLD CAPITAL-RELATED COST				
87	NEW CAPITAL-RELATED COST				
88	NON PHYSICIAN ANESTHETIST				
89	MEDICAL EDUCATION				
9.01	MEDICAL EDUCATION - ALLIED HEA				
9.02	MEDICAL EDUCATION - ALL OTHER				

TITLE XIX - I/P HOSPITAL PPS

1

I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	2,348
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,186
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,186
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	162
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	233
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	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)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	244
16	NURSERY DAYS (TITLE V OR XIX ONLY)	182

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,272,214
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	225,766
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,046,448

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	773,084
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	773,084
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	3.940643
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	353.65
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3,046,448

TITLE XIX - I/P HOSPITAL PPS

II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE  
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 1,393.62  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 324,713  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 324,713

	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST
	1	2	3	4	5
42 NURSERY (TITLE V & XIX ONLY)	207,503	244	850.42	182	154,776
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1 516,261
49 TOTAL PROGRAM INPATIENT COSTS					995,750

PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES 49,506  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES 42,610  
 52 TOTAL PROGRAM EXCLUDABLE COST 92,116  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN  
 ANESTHETIST, AND MEDICAL EDUCATION COSTS 903,634

TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES  
 55 TARGET AMOUNT PER DISCHARGE  
 56 TARGET AMOUNT  
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT  
 BONUS PAYMENT  
 58.01 LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED  
 AND COMPOUNDED BY THE MARKET BASKET  
 58.02 LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET  
 BASKET  
 58.03 IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE  
 LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN  
 EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56)  
 OTHERWISE ENTER ZERO.  
 58.04 RELIEF PAYMENT  
 59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT  
 59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)  
 59.02 PROGRAM DISCHARGES PRIOR TO JULY 1  
 59.03 PROGRAM DISCHARGES AFTER JULY 1  
 59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)  
 59.05 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1  
 (SEE INSTRUCTIONS) (LTCH ONLY)  
 59.06 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1  
 (SEE INSTRUCTIONS) (LTCH ONLY)  
 59.07 REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)  
 59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST  
 REPORTING PERIOD (SEE INSTRUCTIONS)  
 61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST  
 REPORTING PERIOD (SEE INSTRUCTIONS)  
 62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS  
 63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE  
 COST REPORTING PERIOD  
 64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE  
 COST REPORTING PERIOD  
 65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

COMPUTATION OF INPATIENT OPERATING COST

TITLE XIX - I/P HOSPITAL PPS

PART III - SKILLED NURSING FACILITY, NURSING FACILITY & ICF/MR ONLY

66 SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST  
 67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM  
 68 PROGRAM ROUTINE SERVICE COST  
 69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM  
 70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS  
 71 CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS  
 72 PER DIEM CAPITAL-RELATED COSTS  
 73 PROGRAM CAPITAL-RELATED COSTS  
 74 INPATIENT ROUTINE SERVICE COST  
 75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS  
 76 TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION  
 77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION  
 78 INPATIENT ROUTINE SERVICE COST LIMITATION  
 79 REASONABLE INPATIENT ROUTINE SERVICE COSTS  
 80 PROGRAM INPATIENT ANCILLARY SERVICES  
 81 UTILIZATION REVIEW - PHYSICIAN COMPENSATION  
 82 TOTAL PROGRAM INPATIENT OPERATING COSTS

1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BED DAYS 1,161  
 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 1,393.62  
 85 OBSERVATION BED COST 1,617,993

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86 OLD CAPITAL-RELATED COST		3,046,448		1,617,993	
87 NEW CAPITAL-RELATED COST	403,210	3,046,448	.132354	1,617,993	214,148
88 NON PHYSICIAN ANESTHETIST		3,046,448		1,617,993	
89 MEDICAL EDUCATION		3,046,448		1,617,993	
90.01 MEDICAL EDUCATION - ALLIED HEA					
90.02 MEDICAL EDUCATION - ALL OTHER					

TITLE XVIII, PART A HOSPITAL OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		383,658	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.489949	4,934	2,417
39	DELIVERY ROOM & LABOR ROOM	.631870	7,096	4,484
41	RADIOLOGY-DIAGNOSTIC	.214123	53,011	11,351
44	LABORATORY	.332723	102,634	34,149
48	INTRAVENOUS THERAPY	.321081	49,285	15,824
49	RESPIRATORY THERAPY	.800790	47,053	37,680
50	PHYSICAL THERAPY	.510701	44,499	22,726
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.733384	132,305	97,030
55	30 IMPL. DEV. CHARGED TO PATIENT	.361938		
56	DRUGS CHARGED TO PATIENTS	.318437	336,626	107,194
59	ACUPUNCTURE			
59	97 CARDIAC REHABILITATION	2.088615		
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.513993	342	176
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.903853		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		777,785	333,031
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		777,785	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

TITLE XVIII, PART A

SWING BED SNF

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.489949		
39	DELIVERY ROOM & LABOR ROOM	.631870		
41	RADIOLOGY-DIAGNOSTIC	.214123	1,045	224
44	LABORATORY	.332723	3,300	1,098
48	INTRAVENOUS THERAPY	.321081		
49	RESPIRATORY THERAPY	.800790	2,687	2,152
50	PHYSICAL THERAPY	.510701	43,965	22,453
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.733384	8,997	6,598
55	30 IMPL. DEV. CHARGED TO PATIENT	.361938		
56	DRUGS CHARGED TO PATIENTS	.318437	38,269	12,186
59	ACUPUNCTURE			
59	97 CARDIAC REHABILITATION	2.088615		
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.513993		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.903853		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		98,263	44,711
102	LESS PBP CLINIC LABORATORY SERVICES -- PROGRAM ONLY CHARGES			
103	NET CHARGES		98,263	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

WKST A	TITLE XIX	HOSPITAL	RATIO COST	INPATIENT	INPATIENT
LINE NO.	COST CENTER DESCRIPTION		TO CHARGES	CHARGES	COST
			1	2	3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			209,678	
	ANCILLARY SRVC COST CNTRS				
37	OPERATING ROOM		.489949	330,416	161,887
39	DELIVERY ROOM & LABOR ROOM		.631870	304,371	192,323
41	RADIOLOGY-DIAGNOSTIC		.214123	15,638	3,348
44	LABORATORY		.332723	126,543	42,104
48	INTRAVENOUS THERAPY		.321081	26,149	8,396
49	RESPIRATORY THERAPY		.800790	35,807	28,674
50	PHYSICAL THERAPY		.510701	1,812	925
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		.733384	16,393	12,022
55	30 IMPL. DEV. CHARGED TO PATIENT		.361938		
56	DRUGS CHARGED TO PATIENTS		.318437	179,459	57,146
59	ACUPUNCTURE				
59	97 CARDIAC REHABILITATION		2.088615		
	OUTPAT SERVICE COST CNTRS				
61	EMERGENCY		.513993	18,358	9,436
62	OBSERVATION BEDS (NON-DISTINCT PART)		1.903853		
	OTHER REIMBURS COST CNTRS				
65	AMBULANCE SERVICES				
101	TOTAL			1,054,946	516,261
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES				
103	NET CHARGES			1,054,946	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) 5,332,763  
 1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).  
 1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.  
 1.03 ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.  
 1.04 LINE 1.01 TIMES LINE 1.03.  
 1.05 LINE 1.02 DIVIDED BY LINE 1.04.  
 1.06 TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)  
 1.07 OUTPATIENT ANCILLARY PASSTHRU COSTS FROM (W/S D,IV (COLS 9, 9.01, 9.02) LINE 101  
 2 INTERNS AND RESIDENTS  
 3 ORGAN ACQUISITIONS  
 4 COST OF TEACHING PHYSICIANS  
 5 TOTAL COST (SEE INSTRUCTIONS) 5,332,763

COMPUTATION OF LESSER OF COST OR CHARGES

REASONABLE CHARGES  
 6 ANCILLARY SERVICE CHARGES  
 7 INTERNS AND RESIDENTS SERVICE CHARGES  
 8 ORGAN ACQUISITION CHARGES  
 9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.  
 10 TOTAL REASONABLE CHARGES  
 CUSTOMARY CHARGES  
 11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS  
 12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).  
 13 RATIO OF LINE 11 TO LINE 12  
 14 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)  
 15 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST  
 16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES  
 17 LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC) 5,386,091  
 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18 CAH DEDUCTIBLES 33,143  
 18.01 CAH ACTUAL BILLED COINSURANCE 2,102,446  
 LINE 17.01 (SEE INSTRUCTIONS)  
 19 SUBTOTAL (SEE INSTRUCTIONS) 3,250,502  
 20 SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)  
 21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS  
 22 ESRD DIRECT MEDICAL EDUCATION COSTS  
 23 SUBTOTAL 3,250,502  
 24 PRIMARY PAYER PAYMENTS 1,888  
 25 SUBTOTAL 3,248,614  
 REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)  
 26 COMPOSITE RATE ESRD  
 27 BAD DEBTS (SEE INSTRUCTIONS) 748,649  
 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) 748,649  
 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES 606,662  
 28 SUBTOTAL 3,997,263  
 29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.  
 30 OTHER ADJUSTMENTS (SPECIFY)  
 30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)  
 31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.  
 32 SUBTOTAL 3,997,263  
 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)  
 34 INTERIM PAYMENTS 3,156,942  
 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)  
 35 BALANCE DUE PROVIDER/PROGRAM 840,321  
 36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2

TO BE COMPLETED BY CONTRACTOR

50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)  
 51 OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)  
 52 THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY  
 53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)  
 54 TOTAL (SUM OF LINES 51 AND 53)

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		717,846		3,330,230
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 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)				
ADJUSTMENTS TO PROVIDER .01	8/12/2010	33,485	12/16/2010	55,770
ADJUSTMENTS TO PROVIDER .02	12/16/2010	13,109		
ADJUSTMENTS TO PROVIDER .03	12/16/2010	2,092		
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROVIDER .49				
ADJUSTMENTS TO PROGRAM .50			8/12/2010	155,354
ADJUSTMENTS TO PROGRAM .51			12/16/2010	73,704
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL		48,686		-173,288
4 TOTAL INTERIM PAYMENTS		766,532		3,156,942
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		169,669		840,321
7 TOTAL MEDICARE PROGRAM LIABILITY		936,201		3,997,263

NAME OF INTERMEDIARY:  
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		197,456		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 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)				
ADJUSTMENTS TO PROVIDER .01	8/12/2010	10,184		
ADJUSTMENTS TO PROVIDER .02	12/16/2010	3,350		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROVIDER .49				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL		13,534		NONE
4 TOTAL INTERIM PAYMENTS		210,990		
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
TENTATIVE TO PROGRAM .99				
SUBTOTAL		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		37,989		
7 TOTAL MEDICARE PROGRAM LIABILITY		248,979		

NAME OF INTERMEDIARY:  
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

CALCULATION OF REIMBURSEMENT SETTLEMENT  
 SWING BEDS

TITLE XVIII      SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	204,096	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	45,158	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	145	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	249,254	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	249,254	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	249,254	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		275
14	80% OF PART B COSTS		
15	SUBTOTAL	248,979	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	248,979	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	210,990	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	37,989	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT  
 HOSPITAL

1	INPATIENT SERVICES	1,060,501
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	1,060,501
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	1,071,106
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	1,071,106
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	164,449
21	EXCESS REASONABLE COST	
22	SUBTOTAL	906,657
23	COINSURANCE	
24	SUBTOTAL	906,657
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	29,544
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	29,544
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	22,753
26	SUBTOTAL	936,201
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	936,201
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	766,532
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	169,669
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

BALANCE SHEET

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	13,723,630			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	5,979,046			
5	OTHER RECEIVABLES				
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-3,830,149			
7	INVENTORY	647,539			
8	PREPAID EXPENSES	290,001			
9	OTHER CURRENT ASSETS	116,808			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	16,926,875			
FIXED ASSETS					
12	LAND	78,263			
12.01	LAND IMPROVEMENTS	508,588			
13	LESS ACCUMULATED DEPRECIATION				
13.01	BUILDINGS	10,399,718			
14	LESS ACCUMULATED DEPRECIATION				
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT	4,212,714			
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION	-7,409,917			
20	MINOR EQUIPMENT-NONDEPRECIABLE	123,448			
21	TOTAL FIXED ASSETS	7,912,814			
OTHER ASSETS					
22	INVESTMENTS	2,227,668			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS				
26	TOTAL OTHER ASSETS	2,227,668			
27	TOTAL ASSETS	27,067,357			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
<b>LIABILITIES AND FUND BALANCE</b>				
<b>CURRENT LIABILITIES</b>				
28 ACCOUNTS PAYABLE	2,306,010			
29 SALARIES, WAGES & FEES PAYABLE	1,210,300			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)				
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	1,049,005			
36 TOTAL CURRENT LIABILITIES	4,565,315			
<b>LONG TERM LIABILITIES</b>				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	3,174,320			
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES	264,000			
42 TOTAL LONG-TERM LIABILITIES	3,438,320			
43 TOTAL LIABILITIES	8,003,635			
<b>CAPITAL ACCOUNTS</b>				
44 GENERAL FUND BALANCE	19,063,722			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	19,063,722			
52 TOTAL LIABILITIES AND FUND BALANCES	27,067,357			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		15,391,030		
2 NET INCOME (LOSS)		3,672,692		
3 TOTAL		19,063,722		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADDITIONS (CREDIT ADJUSTM				
6				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL		19,063,722		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM				
14				
15				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		19,063,722		

	ENDOWMENT FUND		PLANT FUND	
	5	6	7	8
1 FUND BALANCE AT BEGINNING OF PERIOD				
2 NET INCOME (LOSS)				
3 TOTAL				
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADDITIONS (CREDIT ADJUSTM				
6				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL				
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM				
14				
15				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET				

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	919,586		919,586
4 00 SWING BED - SNF	72,536		72,536
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	992,122		992,122
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	992,122		992,122
17 00 ANCILLARY SERVICES	3,227,253	43,810,111	47,037,364
18 00 OUTPATIENT SERVICES		849,852	849,852
20 00 AMBULANCE SERVICES		2,877,545	2,877,545
24 00			
25 00 TOTAL PATIENT REVENUES	4,219,375	47,537,508	51,756,883

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		20,754,634	
ADD (SPECIFY)			
27 00 BAD DEBT EXPENSE	3,974,264		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		3,974,264	
DEDUCT (SPECIFY)			
34 00 RECLASS OF EXPENSE TO REVENUE	1,108		
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS		1,108	
40 00 TOTAL OPERATING EXPENSES		24,727,790	

STATEMENT OF REVENUES AND EXPENSES

DESCRIPTION		
1	TOTAL PATIENT REVENUES	51,756,883
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	24,037,731
3	NET PATIENT REVENUES	27,719,152
4	LESS: TOTAL OPERATING EXPENSES	24,727,790
5	NET INCOME FROM SERVICE TO PATIENTS	2,991,362
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	178,108
7	INCOME FROM INVESTMENTS	299,501
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	4,795
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	31,368
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	7,038
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	10,934
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	2,407
22	RENTAL OF HOSPITAL SPACE	91,075
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER (SPECIFY)	56,104
25	TOTAL OTHER INCOME	681,330
26	TOTAL	3,672,692
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	3,672,692