

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).

FORM APPROVED
 OMB NO. 0938-0050

WORKSHEET S
 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	15-1332	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	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/31/2011 TIME 11:17

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:
 DECATUR CO. MEMORIAL 15-1332
 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.

 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2	3	4		
1	HOSPITAL	0	240,299	428,426	0	
3	SWING BED - SNF	0	30,806	0	0	
7	HOSPITAL-BASED HHA	0	0	0	0	
100	TOTAL	0	271,105	428,426	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.

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET S-2
 I I TO 12/31/2010 I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 702 NORTH LINCOLN STREET P.O. BOX:
 1.01 CITY: GREENSBURG STATE: IN ZIP CODE: 47240-1398 COUNTY: DECATUR

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N)
02.00 HOSPITAL	DECATUR CO. MEMORIAL	15-1332	2.01	12/ 1/2005	V XVIII XIX
04.00 SWING BED - SNF	DECATUR CO. SWING BED	15-2332		12/ 1/2005	4 5 6
09.00 HOSPITAL-BASED HHA	DECATUR CO. HHA	15-7153		3/ 1/1985	N O P

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 N Y

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. N

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.

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) N N

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) N N

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 12/ 1/2005

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. 1 2 3 4

ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS) 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) Y

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). N

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)? N
- 35.03 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N
- 35.04 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N

- V XVIII XIX
- PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL 1 2 3
 - 36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N
 - 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
- 40.01 NAME: FI/CONTRACTOR NAME FI/CONTRACTOR #
- 40.02 STREET: P.O. BOX:
- 40.03 CITY: 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? Y
- 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? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2. N 00/00/0000
- 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 NHCNQ 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	N	N	N	N	N
50.00 HHA	N	N			

- 52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N
- 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 N
- 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: 241,927
 - 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 0	Y OR N 1	LIMIT 2	Y OR N 3	FEES 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

61.00 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).	N	/ /
---	---	-----

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

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET S-3
 I I TO 12/31/2010 I PART I

COMPONENT	I & R FTES	--- FULL TIME	EQUIV ---	-----	DISCHARGES	-----	TOTAL ALL
	NET	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	PATIENTS
27 AMBULANCE TRIPS	9	10	11	12	13	14	15
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

HOME HEALTH AGENCY STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
I 15-1332 I FROM 1/ 1/2010 I WORKSHEET S-4
I HHA NO: I TO 12/31/2010 I
I 15-7153 I
COUNTY:

HHA 1

	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4
1 HOME HEALTH AIDE HOURS	0	0	0	0
2 UNDUPLICATED CENSUS COUNT		250.00		

TOTAL
5

1 HOME HEALTH AIDE HOURS	0
2 UNDUPLICATED CENSUS COUNT	

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES
(FULL TIME EQUIVALENT)

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK

HHA NO. OF FTE EMPLOYEES (2080 HRS)

	STAFF 1	CONTRACT 2	TOTAL 3
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)			
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			
5 OTHER ADMINISTRATIVE PERSONEL			
6 DIRECTING NURSING SERVICE			
7 NURSING SUPERVISOR			
8 PHYSICAL THERAPY SERVICE			
9 PHYSICAL THERAPY SUPERVISOR			
10 OCCUPATIONAL THERAPY SERVICE			
11 OCCUPATIONAL THERAPY SUPERVISOR			
12 SPEECH PATHOLOGY SERVICE			
13 SPEECH PATHOLOGY SUPERVISOR			
14 MEDICAL SOCIAL SERVICE			
15 MEDICAL SOCIAL SERVICE SUPERVISOR			
16 HOME HEALTH AIDE			
17 HOME HEALTH AIDE SUPERVISOR			
18			

HOME HEALTH AGENCY MSA CODES 1 1.01

19 HOW MANY MSAs IN COL. 1 OR CBSAs IN COL. 1.01 DID YOU PROVIDER SERVICES TO DURING THE C/R PERIOD? 0 0

20 LIST THOSE MSA CODE(S) IN COL. 1 & CBSA CODE(S) IN COL. 1.01 SERVICED DURING THIS C/R PERIOD (LINE 20 CONTAINS THE FIRST CODE).

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON OR AFTER OCTOBER 1, 2000

	FULL EPISODES		LUPA	PEP ONLY
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	EPISODES 3	EPISODES 4
21 SKILLED NURSING VISITS	2,739	150	238	21
22 SKILLED NURSING VISIT CHARGES	496,682	27,300	43,260	3,798
23 PHYSICAL THERAPY VISITS	1,217	1	25	54
24 PHYSICAL THERAPY VISIT CHARGES	220,806	182	4,534	9,812
25 OCCUPATIONAL THERAPY VISITS	376	1	4	8
26 OCCUPATIONAL THERAPY VISIT CHARGES	68,016	182	728	1,448
27 SPEECH PATHOLOGY VISITS	17	0	1	0
28 SPEECH PATHOLOGY VISIT CHARGES	2,998	0	182	0
29 MEDICAL SOCIAL SERVICE VISITS	23	0	1	2
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	4,178	0	182	364
31 HOME HEALTH AIDE VISITS	1,277	50	3	32
32 HOME HEALTH AIDE VISIT CHARGES	139,895	5,500	330	3,520
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	5,649	202	272	117
34 OTHER CHARGES	0	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	932,575	33,164	49,216	18,942
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	351	0	92	9
37 TOTAL NUMBER OF OUTLIER EPISODES	0	4	0	1
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	64,364	5,119	1,873	684

HOSPITAL-BASED HOME HEALTH AGENCY
 STATISTICAL DATA
 HOME HEALTH AGENCY STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET S-4
 I HHA NO: I TO 12/31/2010 I
 I 15-7153 I
 COUNTY:

HHA 1

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON
 OR AFTER OCTOBER 1, 2000

	SCIC WITHIN A PEP 5	SCIC ONLY EPISODES 6	TOTAL (COLS. 1-6) 7
21 SKILLED NURSING VISITS	0	0	3,148
22 SKILLED NURSING VISIT CHARGES	0	0	571,040
23 PHYSICAL THERAPY VISITS	0	0	1,297
24 PHYSICAL THERAPY VISIT CHARGES	0	0	235,334
25 OCCUPATIONAL THERAPY VISITS	0	0	389
26 OCCUPATIONAL THERAPY VISIT CHARGES	0	0	70,374
27 SPEECH PATHOLOGY VISITS	0	0	18
28 SPEECH PATHOLOGY VISIT CHARGES	0	0	3,180
29 MEDICAL SOCIAL SERVICE VISITS	0	0	26
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	4,724
31 HOME HEALTH AIDE VISITS	0	0	1,362
32 HOME HEALTH AIDE VISIT CHARGES	0	0	149,245
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	0	0	6,240
34 OTHER CHARGES	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	0	0	1,033,897
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	0	0	452
37 TOTAL NUMBER OF OUTLIER EPISODES	0	0	5
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	0	0	72,040

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I 15-1332 I

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

I PREPARED 5/31/2011 I WORKSHEET A I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		1,000,790	1,000,790		1,000,790
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		1,717,052	1,717,052		1,717,052
5	0500 EMPLOYEE BENEFITS	153,178	5,506,985	5,660,163	11,148	5,671,311
6	0600 ADMINISTRATIVE & GENERAL	2,129,086	2,027,060	4,156,146	302,639	4,458,785
7	0700 MAINTENANCE & REPAIRS	431,053	249,381	680,434	-45,220	635,214
8	0800 OPERATION OF PLANT		595,364	595,364	3,732	599,096
9	0900 LAUNDRY & LINEN SERVICE	54,996	16,217	71,213		71,213
10	1000 HOUSEKEEPING	389,426	205,506	594,932		594,932
11	1100 DIETARY	375,259	300,341	675,600	-479,066	196,534
12	1200 CAFETERIA				479,066	479,066
13	1300 MAINTENANCE OF PERSONNEL					
14	1400 NURSING ADMINISTRATION	721,468	21,277	742,745		742,745
15	1500 CENTRAL SERVICES & SUPPLY	28,230	1,742	29,972		29,972
16	1600 PHARMACY					
17	1700 MEDICAL RECORDS & LIBRARY	399,595	65,774	465,369	88,716	554,085
18	1800 SOCIAL SERVICE	127,459	2,727	130,186		130,186
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	2,437,988	69,775	2,507,763	-230,520	2,277,243
26	2600 INTENSIVE CARE UNIT	339,202	16,013	355,215		355,215
33	3300 NURSERY				158,624	158,624
36	3600 OTHER LONG TERM CARE					
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	1,013,371	66,459	1,079,830		1,079,830
39	3900 DELIVERY ROOM & LABOR ROOM				71,896	71,896
40	4000 ANESTHESIOLOGY	417,864	267,255	685,119	45,220	730,339
41	4100 RADIOLOGY-DIAGNOSTIC	1,180,813	651,752	1,832,565	-77,217	1,755,348
41.01	3630 ULTRA SOUND		51,201	51,201	77,217	128,418
44	4400 LABORATORY	960,695	398,873	1,359,568		1,359,568
46	4600 WHOLE BLOOD & PACKED RED BLOOD CELLS		77,862	77,862		77,862
46.30	4650 BLOOD CLOTTING FACTORS ADMIN COSTS					
49	4900 RESPIRATORY THERAPY	644,869	56,010	700,879	-97,376	603,503
50	5000 PHYSICAL THERAPY	524,949	15,261	540,210		540,210
51	5100 OCCUPATIONAL THERAPY	160,328	4,419	164,747		164,747
52	5200 SPEECH PATHOLOGY	272,160	33,062	305,222		305,222
53	5300 ELECTROCARDIOLOGY		208,048	208,048	97,376	305,424
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		2,415,226	2,415,226	-18,510	2,396,716
55.30	5530 IMPL. DEV. CHARGED TO PATIENT				18,510	18,510
56	5600 DRUGS CHARGED TO PATIENTS	691,225	1,957,003	2,648,228		2,648,228
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	502,509	94,421	596,930		596,930
60.01	6001 ONCOLOGY	203,250	105,538	308,788		308,788
60.02	6002 OUTPATIENT CLINIC	93,105	175,180	268,285		268,285
60.03	6003 PROVIDER BASED CLINIC - TCMP	575,809	1,429,497	2,005,306	-249,434	1,755,872
60.04	6004 PROVIDER BASED CLINIC - DCPC	789,450	65,353	854,803	-83,549	771,254
60.05	6005 PROVIDER BASED CLINIC - WESTPORT	114,899	15,269	130,168	-25,278	104,890
60.06	6006 CLINIC	91,156	121,827	212,983		212,983
61	6100 EMERGENCY	2,037,966	204,621	2,242,587		2,242,587
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63.50	6310 RHC					
63.60	6320 FQHC					
	OTHER REIMBURS COST CNTRS					
65	6500 AMBULANCE SERVICES	570,948	71,356	642,304		642,304
69.10	6910 CMHC					
69.20	6920 OUTPATIENT PHYSICAL THERAPY					
69.30	6930 OUTPATIENT OCCUPATIONAL THERAPY					
69.40	6940 OUTPATIENT SPEECH PATHOLOGY					
71	7100 HOME HEALTH AGENCY	1,019,781	127,700	1,147,481		1,147,481
	SPEC PURPOSE COST CENTERS					
85.01	8510 PANCREAS ACQUISITION					
85.02	8520 INTESTINAL ACQUISITION					
85.03	8530 ISLET CELL ACQUISITION					
90	9000 OTHER CAPITAL RELATED COSTS					
95	SUBTOTALS	19,452,087	20,409,197	39,861,284	47,974	39,909,258
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		5,148	5,148		5,148
98	9800 PHYSICIANS' PRIVATE OFFICES					
100	7950 MARKETING	128,592	299,457	428,049	-47,974	380,075
100.01	7951 WOMEN'S HEALTH SERVICES	26,759	75,863	102,622		102,622
101	TOTAL	19,607,438	20,789,665	40,397,103	-0-	40,397,103

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSESI PROVIDER NO:
I 15-1332
II PERIOD:
I FROM 1/ 1/2010
I TO 12/31/2010 II PREPARED 5/31/2011
I WORKSHEET A
I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-212,657	788,133
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-2,073	1,714,979
5	0500 EMPLOYEE BENEFITS	-430,014	5,241,297
6	0600 ADMINISTRATIVE & GENERAL	-36,214	4,422,571
7	0700 MAINTENANCE & REPAIRS		635,214
8	0800 OPERATION OF PLANT		599,096
9	0900 LAUNDRY & LINEN SERVICE		71,213
10	1000 HOUSEKEEPING		594,932
11	1100 DIETARY		196,534
12	1200 CAFETERIA	-135,594	343,472
13	1300 MAINTENANCE OF PERSONNEL		
14	1400 NURSING ADMINISTRATION		742,745
15	1500 CENTRAL SERVICES & SUPPLY		29,972
16	1600 PHARMACY		
17	1700 MEDICAL RECORDS & LIBRARY	-424	553,661
18	1800 SOCIAL SERVICE		130,186
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-9,332	2,267,911
26	2600 INTENSIVE CARE UNIT		355,215
33	3300 NURSERY		158,624
36	3600 OTHER LONG TERM CARE		
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		1,079,830
39	3900 DELIVERY ROOM & LABOR ROOM		71,896
40	4000 ANESTHESIOLOGY	-630,743	99,596
41	4100 RADIOLOGY-DIAGNOSTIC	-1,581	1,753,767
41.01	3630 ULTRA SOUND		128,418
44	4400 LABORATORY		1,359,568
46	4600 WHOLE BLOOD & PACKED RED BLOOD CELLS		77,862
46.30	4650 BLOOD CLOTTING FACTORS ADMIN COSTS		
49	4900 RESPIRATORY THERAPY		603,503
50	5000 PHYSICAL THERAPY		540,210
51	5100 OCCUPATIONAL THERAPY		164,747
52	5200 SPEECH PATHOLOGY		305,222
53	5300 ELECTROCARDIOLOGY	-152,325	153,099
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	-117,326	2,279,390
55.30	5530 IMPL. DEV. CHARGED TO PATIENT		18,510
56	5600 DRUGS CHARGED TO PATIENTS	-5,990	2,642,238
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC	-310,353	286,577
60.01	6001 ONCOLOGY		308,788
60.02	6002 OUTPATIENT CLINIC	-166,287	101,998
60.03	6003 PROVIDER BASED CLINIC - TCMP		501,352
60.04	6004 PROVIDER BASED CLINIC - DCPC	-1,254,520	771,254
60.05	6005 PROVIDER BASED CLINIC - WESTPORT		104,890
60.06	6006 CLINIC	-75,363	137,620
61	6100 EMERGENCY	-922,985	1,319,602
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63.50	6310 RHC		
63.60	6320 FQHC		
	OTHER REIMBURS COST CNTRS		
65	6500 AMBULANCE SERVICES	68,760	711,064
69.10	6910 CMHC		
69.20	6920 OUTPATIENT PHYSICAL THERAPY		
69.30	6930 OUTPATIENT OCCUPATIONAL THERAPY		
69.40	6940 OUTPATIENT SPEECH PATHOLOGY		
71	7100 HOME HEALTH AGENCY		1,147,481
	SPEC PURPOSE COST CENTERS		
85.01	8510 PANCREAS ACQUISITION		
85.02	8520 INTESTINAL ACQUISITION		
85.03	8530 ISLET CELL ACQUISITION		
90	9000 OTHER CAPITAL RELATED COSTS		-0-
95	SUBTOTALS	-4,395,021	35,514,237
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		5,148
98	9800 PHYSICIANS' PRIVATE OFFICES		
100	7950 MARKETING		380,075
100.01	7951 WOMEN'S HEALTH SERVICES		102,622
101	TOTAL	-4,395,021	36,002,082

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I NOT A CMS WORKSHEET
 I I TO 12/31/2010 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
GENERAL SERVICE COST			
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
13	MAINTENANCE OF PERSONNEL	1300	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
INPAT ROUTINE SRVC C			
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
33	NURSERY	3300	
36	OTHER LONG TERM CARE	3600	
ANCILLARY SRVC COST			
37	OPERATING ROOM	3700	
39	DELIVERY ROOM & LABOR ROOM	3900	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
41.01	ULTRA SOUND	3630	ULTRA SOUND
44	LABORATORY	4400	
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	4600	
46.30	BLOOD CLOTTING FACTORS ADMIN COSTS	4650	BLOOD CLOTTING FOR HEMOPHILIACS
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
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	
OUTPAT SERVICE COST			
60	CLINIC	6000	
60.01	ONCOLOGY	6001	CLINIC
60.02	OUTPATIENT CLINIC	6002	CLINIC
60.03	PROVIDER BASED CLINIC - TCMP	6003	CLINIC
60.04	PROVIDER BASED CLINIC - DCPC	6004	CLINIC
60.05	PROVIDER BASED CLINIC - WESTPORT	6005	CLINIC
60.06	CLINIC	6006	CLINIC
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63.50	RHC	6310	RURAL HEALTH CLINIC #####
63.60	FQHC	6320	FEDERALLY QUALIFIED HEALTH CTR #####
OTHER REIMBURS COST			
65	AMBULANCE SERVICES	6500	
69.10	CMHC	6910	CMHC #####
69.20	OUTPATIENT PHYSICAL THERAPY	6920	OPT #####
69.30	OUTPATIENT OCCUPATIONAL THERAPY	6930	OOT #####
69.40	OUTPATIENT SPEECH PATHOLOGY	6940	OSP #####
71	HOME HEALTH AGENCY	7100	
SPEC PURPOSE COST CE			
85.01	PANCREAS ACQUISITION	8510	
85.02	INTESTINAL ACQUISITION	8520	
85.03	ISLET CELL ACQUISITION	8530	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS	0000	
NONREIMBURS COST CEN			
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
100	MARKETING	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	WOMEN'S HEALTH SERVICES	7951	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151332	FROM 1/ 1/2010	5/31/2011
	TO 12/31/2010	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1)	COST CENTER	LINE NO	SALARY	OTHER
	1	2	3	4	5
1 ULTRASOUND SALARY	A	ULTRA SOUND	41.01	77,217	
2 L&D AND NURSERY	B	NURSERY	33	151,199	7,425
3		DELIVERY ROOM & LABOR ROOM	39	68,531	3,365
4 EKG SALARY	C	ELECTROCARDIOLOGY	53	97,376	
5 CAFETERIA	D	CAFETERIA	12	266,095	212,971
6 ANESTHESIA GAS EXPENSE	E	ANESTHESIOLOGY	40		45,220
7 DIRECT EXPENSE ALLOCATION	F	ADMINISTRATIVE & GENERAL	6	265,813	
8		OPERATION OF PLANT	8	3,732	
9		MEDICAL RECORDS & LIBRARY	17	88,716	
10 MARKETING	H	EMPLOYEE BENEFITS	5		11,148
11		ADMINISTRATIVE & GENERAL	6		36,826
12 IMPLANTABLE DEVICES	I	IMPL. DEV. CHARGED TO PATIENT	55.30		18,510
36 TOTAL RECLASSIFICATIONS				1,018,679	335,465

(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: 151332	PERIOD: FROM 1/ 1/2010 TO 12/31/2010	PREPARED 5/31/2011 WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION	----- DECREASE -----				A-7 REF 10
	CODE (1)	COST CENTER 6	LINE NO 7	SALARY 8	
1 ULTRASOUND SALARY	A	RADIOLOGY-DIAGNOSTIC	41	77,217	
2 L&D AND NURSERY	B	ADULTS & PEDIATRICS	25	219,730	10,790
3					
4 EKG SALARY	C	RESPIRATORY THERAPY	49	97,376	
5 CAFETERIA	D	DIETARY	11	266,095	212,971
6 ANESTHESIA GAS EXPENSE	E	MAINTENANCE & REPAIRS	7		45,220
7 DIRECT EXPENSE ALLOCATION	F	PROVIDER BASED CLINIC - TCMP	60.03	249,434	
8		PROVIDER BASED CLINIC - DCPC	60.04	83,549	
9		PROVIDER BASED CLINIC - WESTPORT	60.05	25,278	
10 MARKETING	H	MARKETING	100		47,974
11					
12 IMPLANTABLE DEVICES	I	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		18,510
36 TOTAL RECLASSIFICATIONS				1,018,679	335,465

(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
151332	FROM 1/ 1/2010	5/31/2011
	TO 12/31/2010	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : ULTRASOUND SALARY

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ULTRA SOUND	41.01	77,217	RADIOLOGY-DIAGNOSTIC	41	77,217	
TOTAL RECLASSIFICATIONS FOR CODE A			77,217				77,217

RECLASS CODE: B
EXPLANATION : L&D AND NURSERY

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NURSERY	33	158,624	ADULTS & PEDIATRICS	25	230,520	
2.00	DELIVERY ROOM & LABOR ROOM	39	71,896			0	
TOTAL RECLASSIFICATIONS FOR CODE B			230,520				230,520

RECLASS CODE: C
EXPLANATION : EKG SALARY

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ELECTROCARDIOLOGY	53	97,376	RESPIRATORY THERAPY	49	97,376	
TOTAL RECLASSIFICATIONS FOR CODE C			97,376				97,376

RECLASS CODE: D
EXPLANATION : CAFETERIA

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	CAFETERIA	12	479,066	DIETARY	11	479,066	
TOTAL RECLASSIFICATIONS FOR CODE D			479,066				479,066

RECLASS CODE: E
EXPLANATION : ANESTHESIA GAS EXPENSE

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ANESTHESIOLOGY	40	45,220	MAINTENANCE & REPAIRS	7	45,220	
TOTAL RECLASSIFICATIONS FOR CODE E			45,220				45,220

RECLASS CODE: F
EXPLANATION : DIRECT EXPENSE ALLOCATION

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ADMINISTRATIVE & GENERAL	6	265,813	PROVIDER BASED CLINIC - TCMP	60.03	249,434	
2.00	OPERATION OF PLANT	8	3,732	PROVIDER BASED CLINIC - DCPC	60.04	83,549	
3.00	MEDICAL RECORDS & LIBRARY	17	88,716	PROVIDER BASED CLINIC - WESTPO	60.05	25,278	
TOTAL RECLASSIFICATIONS FOR CODE F			358,261				358,261

RECLASS CODE: H
EXPLANATION : MARKETING

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	EMPLOYEE BENEFITS	5	11,148	MARKETING	100	47,974	
2.00	ADMINISTRATIVE & GENERAL	6	36,826			0	
TOTAL RECLASSIFICATIONS FOR CODE H			47,974				47,974

RECLASS CODE: I
EXPLANATION : IMPLANTABLE DEVICES

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	IMPL. DEV. CHARGED TO PATIENT	55.30	18,510	MEDICAL SUPPLIES CHARGED TO PA	55	18,510	
TOTAL RECLASSIFICATIONS FOR CODE I			18,510				18,510

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	905,928	760,523		760,523		1,666,451	
2 LAND IMPROVEMENTS	353,413					353,413	
3 BUILDINGS & FIXTURE	25,339,085					25,339,085	
4 BUILDING IMPROVEMEN							
5 FIXED EQUIPMENT	2,332,732	11,180		11,180		2,343,912	
6 MOVABLE EQUIPMENT	14,776,008	87,124		87,124		14,863,132	
7 SUBTOTAL	43,707,166	858,827		858,827		44,565,993	
8 RECONCILING ITEMS							
9 TOTAL	43,707,166	858,827		858,827		44,565,993	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			TOTAL
	GROSS ASSETS	CAPITIALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	
*	1	2	3	4	5	6	7	8
3 NEW CAP REL COSTS-BL								
4 NEW CAP REL COSTS-MV								
5 TOTAL				1.000000				

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						OTHER CAPITAL RELATED COST	TOTAL (1)
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES			
*	9	10	11	12	13	14	15	
3 NEW CAP REL COSTS-BL	788,133						788,133	
4 NEW CAP REL COSTS-MV	1,610,347	104,632					1,714,979	
5 TOTAL	2,398,480	104,632					2,503,112	

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

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						OTHER CAPITAL RELATED COST	TOTAL (1)
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES			
*	9	10	11	12	13	14	15	
3 NEW CAP REL COSTS-BL	788,133		212,657				1,000,790	
4 NEW CAP REL COSTS-MV	1,612,420	104,632					1,717,052	
5 TOTAL	2,400,553	104,632	212,657				2,717,842	

* 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 15-1332 I
I I

I PERIOD: I PREPARED 5/31/2011
I FROM 1/ 1/2010 I WORKSHEET A-8
I TO 12/31/2010 I

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON		WKST. A-7 REF. 5
			WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO	
	1	2	3	4	
1			**COST CENTER DELETED**	1	
2			**COST CENTER DELETED**	2	
3			NEW CAP REL COSTS-BLDG &	3	
4			NEW CAP REL COSTS-MVBLE E	4	
5					
6					
7					
8					
9					
10					
11					
12	A-8-2	-3,512,576			
13					
14	A-8-1	68,760			
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	A-8-3				
28			**COST CENTER DELETED**	89	
29			**COST CENTER DELETED**	1	
30			**COST CENTER DELETED**	2	
31			NEW CAP REL COSTS-BLDG &	3	6
32			NEW CAP REL COSTS-MVBLE E	4	
33			**COST CENTER DELETED**	20	
34					
35	A-8-4		OCCUPATIONAL THERAPY	51	
36	A-8-4		SPEECH PATHOLOGY	52	
37	B	-3,893	ADMINISTRATIVE & GENERAL	6	
38	B	-107,499	CAFETERIA	12	
39	B	-28,095	CAFETERIA	12	
40	B	-424	MEDICAL RECORDS & LIBRARY	17	
41	B	-9,332	ADULTS & PEDIATRICS	25	
42	B	-1,581	RADIOLOGY-DIAGNOSTIC	41	
43	B	-113,418	MEDICAL SUPPLIES CHARGED	55	
44	B	-900	MEDICAL SUPPLIES CHARGED	55	
45	B	-3,008	MEDICAL SUPPLIES CHARGED	55	
46	B	-5,003	DRUGS CHARGED TO PATIENTS	56	
47	B	-4,469	ADMINISTRATIVE & GENERAL	6	
48	B	-54	ADMINISTRATIVE & GENERAL	6	
49	B	-260	ADMINISTRATIVE & GENERAL	6	
49.01	B	-1,174	ADMINISTRATIVE & GENERAL	6	
49.02	A	-8,938	ADMINISTRATIVE & GENERAL	6	
49.03	A	-212,657	NEW CAP REL COSTS-BLDG &	3	11
49.04	A	-987	DRUGS CHARGED TO PATIENTS	56	
49.05	A	-12,034	ADMINISTRATIVE & GENERAL	6	
49.06	A	-2,095	EMPLOYEE BENEFITS	5	
49.07	A	-2,073	NEW CAP REL COSTS-MVBLE E	4	9
49.08	A	-427,919	EMPLOYEE BENEFITS	5	
49.09	A	-5,392	ADMINISTRATIVE & GENERAL	6	
49.10					
49.11					
49.12					
49.13					
50		-4,395,021			

(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	65	AMBULANCE SERVICES		68,760		
2					68,760	
3						
4						
5		TOTALS		68,760		68,760

* 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
1	G	DECATUR COUNTY		0.00	
2				0.00	
3				0.00	
4				0.00	
5				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.
 COUNTY AMBULANCE

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO:
I 15-1332
I

I PERIOD:
I FROM 1/ 1/2010 I PREPARED 5/31/2011
I TO 12/31/2010 I WORKSHEET A-8-2
I GROUP 1

WKSHT A	COST CENTER/ PHYSICIAN	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
LINE NO.	IDENTIFIER	3	4	5	6	7	8	9
1 26	ADVANCED CARE UNIT	11,000		11,000				
2 40	ANESTHESIA PROF SVC	249,228	249,228					
3 40	ANESTHESIA PROF SVC	362,577	330,577	32,000				
4 40	ANESTHESIA PROF SVC	55,869	50,938	4,931				
5								
6 44	LABORATORY	50,000		50,000				
7 49	CARDIOPULMONARY SERVICES	11,000		11,000				
8 49	CARDIAC REHAB	4,998		4,998				
9 53	ELECTRODIAGNOSIS	152,325	152,325					
10 60	PHY MEDICINE	312,912	297,912	15,000				
11 60	PHY MEDICINE	13,067	12,441	626				
12 60	1 NURSING ONCOLOGY	12,000		12,000				
13 60	2 OUTPATIENT CLINIC	166,287	166,287					
14 60	3 TREE CITY MEDICAL PARTNER	1,254,520	1,254,520					
15 60	6 WOUND CARE FACITLITY	2,895	2,895					
16 60	6 WOUND CARE FACITLITY	79,863	72,468	7,395				
17								
18 61	EMERGENCY ROOM PHYSICIANS	174,692	140,786	33,906				
19 61	EMERGENCY ROOM PHYSICIANS	926,068	707,645	218,423				
20 61	EMERGENCY ROOM PHYSICIANS	92,509	74,554	17,955				
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	3,931,810	3,512,576	419,234				

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

I PROVIDER NO: I 15-1332 I

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

I PREPARED 5/31/2011 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	18
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	270
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	29
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	5.50
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9		228.00			
10		69.57			
11	34.79	34.79			
12					
12.01					
13					
13.01					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	15,862
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)	15,862
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)	15,862

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 (SEE INSTRUCTIONS)	69.57
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	18,784
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	18,784

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)	1,009
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	1,009
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	160
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	1,169
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)	

PHYSICAL THERAPY

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)
 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL 1,169
 EXPENSE (LINE 28)
 34 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
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)	1	2	3	4	5
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) 18,784
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM 1,169
 PART III, LINE 33, 34, OR 35)
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES
 (FROM PART IV, LINES 44, 45, OR 46)
 60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)

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

I PROVIDER NO:
 I 15-1332
 I

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

I PREPARED 5/31/2011
 I WORKSHEET A-8-4
 I PARTS I - VII

PHYSICAL THERAPY

61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)
 63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 19,953
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 14,364
 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 - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 66.11 COST OF OUTSIDE SUPPLIER SERVICES - CMHC I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 66.21 COST OF OUTSIDE SUPPLIER SERVICES - OPT I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS) 14,364
 66.41 COST OF OUTSIDE SUPPLIER SERVICES - OOT I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 66.51 COST OF OUTSIDE SUPPLIER SERVICES - OSP I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64) 14,364
 68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)
 68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)
 68.11 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CMHC I (LINE 66 DIVIDED BY LINE 67)
 68.21 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- OPT 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) 1.000000
 68.41 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- OOT I (LINE 66 DIVIDED BY LINE 67)
 68.51 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- OSP 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)
 69.11 EXCESS COST OVER LIMITATION-CMHC I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
 69.21 EXCESS COST OVER LIMITATION- OPT 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)
 69.41 EXCESS COST OVER LIMITATION- OOT I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
 69.51 EXCESS COST OVER LIMITATION- OSP 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)

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

I PROVIDER NO:
I 15-1332
I

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

I PREPARED 5/31/2011
I WORKSHEET A-8-4
I PARTS I - VII

SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	106
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	
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	5.50

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		740.13		
10	AHSEA (SEE INSTRUCTIONS)		63.39		
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	31.70	31.70		
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)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	46,917
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)	46,917
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)	46,917

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 (SEE INSTRUCTIONS)	63.39
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	49,444
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	49,444

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)	3,360
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	3,360
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	3,360
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)	

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

SPEECH PATHOLOGY

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)
 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL 3,360
 EXPENSE (LINE 28)
 34 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
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)	1	2	3	4	5
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) 49,444
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM 3,360
 PART III, LINE 33, 34, OR 35)
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES
 (FROM PART IV, LINES 44, 45, OR 46)
 60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)

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

I PROVIDER NO:
I 15-1332
I

I PERIOD:
I FROM 1/ 1/2010 I PREPARED 5/31/2011
I TO 12/31/2010 I WORKSHEET A-8-4
I PARTS I - VII

SPEECH PATHOLOGY

61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	52,804
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	23,314
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 - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	23,314
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.11	COST OF OUTSIDE SUPPLIER SERVICES - CMHC I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.21	COST OF OUTSIDE SUPPLIER SERVICES - OPT I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.41	COST OF OUTSIDE SUPPLIER SERVICES - OOT I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.51	COST OF OUTSIDE SUPPLIER SERVICES - OSP I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	23,314
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)	
68.11	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CMHC I (LINE 66 DIVIDED BY LINE 67)	
68.21	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- OPT 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)	
68.41	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- OOT I (LINE 66 DIVIDED BY LINE 67)	
68.51	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- OSP 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)	
69.11	EXCESS COST OVER LIMITATION-CMHC I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.21	EXCESS COST OVER LIMITATION- OPT 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)	
69.41	EXCESS COST OVER LIMITATION- OOT I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.51	EXCESS COST OVER LIMITATION- OSP 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 5/31/2011
 I 15-1332 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 FEE T	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE FEE T	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	-6	ACCUM. COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	7	TIME SPENT	ENTERED
8	OPERATION OF PLANT	3	SQUARE FEE T	ENTERED
9	LAUNDRY & LINEN SERVICE	9	POUNDS OF LAUNDRY	ENTERED
10	HOUSEKEEPING	10	HOURS OF SERVICE	ENTERED
11	DIETARY	11	MEALS SERVED	ENTERED
12	CAFETERIA	12	HOURS	ENTERED
13	MAINTENANCE OF PERSONNEL	13	NUMBER HOUSED	NOT ENTERED
14	NURSING ADMINISTRATION	14	NRSING HOURS	ENTERED
15	CENTRAL SERVICES & SUPPLY	15	COSTED REQUIS.	ENTERED
16	PHARMACY	16	COSTED REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	17	GROSS CHARGES	ENTERED
18	SOCIAL SERVICE	18	TIME SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION
	8	9	10	11	12	13	14
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT	913,323						
010 LAUNDRY & LINEN SERVICE	8,856	131,655					
011 HOUSEKEEPING	6,556	12,305	949,280				
012 DIETARY	16,876	561		329,339			
013 CAFETERIA	3,936		25,850		571,451		
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION	6,335		4,215		20,290		1,154,419
016 CENTRAL SERVICES & SUPPLY					2,255		7,256
017 PHARMACY							
018 MEDICAL RECORDS & LIBRARY	31,902		8,429		35,842		
025 SOCIAL SERVICE	2,940		1,335		4,524		14,560
026 INPUT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	84,769	50,753	293,702	319,084	94,524		304,192
033 INTENSIVE CARE UNIT	8,106	1,656	16,894	10,255	10,651		34,276
036 NURSERY	4,674	2,714	29,081		5,374		17,294
037 OTHER LONG TERM CARE							
039 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM	66,374	20,734	2,740		43,932		141,380
041 DELIVERY ROOM & LABOR ROO	60,740	3,690	37,503		2,436		7,838
044 ANESTHESIOLOGY					1,777		
041 RADIOLOGY-DIAGNOSTIC	57,450	10,581	56,230		46,994		
041 01 ULTRA SOUND							
044 LABORATORY	29,251		36,737		43,681		3,693
046 WHOLE BLOOD & PACKED RED							
046 30 BLOOD CLOTTING FACTORS AD							
049 RESPIRATORY THERAPY	10,769	1,091	18,910		21,729		69,926
050 PHYSICAL THERAPY	16,926	7,068	16,261		21,783		70,101
051 OCCUPATIONAL THERAPY	9,447		421		5,481		17,640
052 SPEECH PATHOLOGY	8,856		6,041		10,169		32,724
053 ELECTROCARDIOLOGY	4,797	1,218	21,389				
055 MEDICAL SUPPLIES CHARGED	15,007						
055 30 IMPL. DEV. CHARGED TO PAT							
056 DRUGS CHARGED TO PATIENTS	14,170		83,133		25,642		82,520
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC	12,214				2,299		24,995
060 01 ONCOLOGY	5,474	520	18,404		9,037		29,083
060 02 OUTPATIENT CLINIC	38,876	659	40,179		5,995		19,291
060 03 PROVIDER BASED CLINIC - T	102,304	768					
060 04 PROVIDER BASED CLINIC - D	38,747	113	69,120		18,948		
060 05 PROVIDER BASED CLINIC - W	7,380						
060 06 CLINIC	14,822	199	5,690		3,502		11,271
061 EMERGENCY	36,287	14,554	93,881		46,667		119,575
062 OBSERVATION BEDS (NON-DIS							
063 50 RHC							
063 60 FQHC							
065 OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES	22,141	1,995			35,314		
069 10 CMHC							
069 20 OUTPATIENT PHYSICAL THERA							
069 30 OUTPATIENT OCCUPATIONAL T							
069 40 OUTPATIENT SPEECH PATHOLO							
071 HOME HEALTH AGENCY	16,163				43,991		141,569
085 SPEC PURPOSE COST CENTERS							
085 01 PANCREAS ACQUISITION							
085 02 INTESTINAL ACQUISITION							
085 03 ISLET CELL ACQUISITION							
095 SUBTOTALS	763,145	131,179	886,145	329,339	562,837		1,149,184
096 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP	4,151						
100 PHYSICIANS' PRIVATE OFFIC	143,869	476	63,135				
100 MARKETING	1,082				6,987		
100 01 WOMEN'S HEALTH SERVICES	1,076				1,627		5,235
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	913,323	131,655	949,280	329,339	571,451		1,154,419

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	CENTRAL SERVI CES & SUPPLY		MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	SUBTOTAL	I&R COST POST STEP-DOWN ADJ 26	TOTAL
	15	16	17	18	25		27
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE							
011 HOUSEKEEPING							
012 DIETARY							
012 CAFETERIA							
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION							
015 CENTRAL SERVICES & SUPPLY	53,921						
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY			989,070				
018 SOCIAL SERVICE				227,704			
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS			41,508	212,318	5,091,418		5,091,418
033 INTENSIVE CARE UNIT			3,252		643,796		643,796
036 NURSERY			7,131		339,822		339,822
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
039 OPERATING ROOM			98,962		2,209,946		2,209,946
040 DELIVERY ROOM & LABOR ROO			5,389		381,448		381,448
041 ANESTHESIOLOGY			6,105		258,689		258,689
041 RADIOLOGY-DIAGNOSTIC			221,382		3,095,309		3,095,309
041 01 ULTRA SOUND			23,953		200,297		200,297
044 LABORATORY			162,409		2,270,284		2,270,284
046 WHOLE BLOOD & PACKED RED			6,083		98,088		98,088
046 30 BLOOD CLOTTING FACTORS AD							
049 RESPIRATORY THERAPY			25,127		1,065,608		1,065,608
050 PHYSICAL THERAPY			27,310		1,030,463		1,030,463
051 OCCUPATIONAL THERAPY			7,007		308,283		308,283
052 SPEECH PATHOLOGY			9,313		537,528		537,528
053 ELECTROCARDIOLOGY			34,438		285,218		285,218
055 MEDICAL SUPPLIES CHARGED	53,921		55,130		2,853,294		2,853,294
055 30 IMPL. DEV. CHARGED TO PAT			354		22,226		22,226
056 DRUGS CHARGED TO PATIENTS			114,225		3,702,642		3,702,642
056 OUTPAT SERVICE COST CNTRS							
060 CLINIC			3,483		570,850		570,850
060 01 ONCOLOGY			3,418	684	518,946		518,946
060 02 OUTPATIENT CLINIC			3,236		414,795		414,795
060 03 PROVIDER BASED CLINIC - T			12,772		1,135,943		1,135,943
060 04 PROVIDER BASED CLINIC - D			7,515		1,382,010		1,382,010
060 05 PROVIDER BASED CLINIC - W			1,266		186,460		186,460
060 06 CLINIC			1,846		289,415		289,415
061 EMERGENCY			75,249	4,103	2,699,892		2,699,892
062 OBSERVATION BEDS (NON-DIS							
063 50 RHC							
063 60 FQHC							
065 OTHER REIMBURS COST CNTRS							
065 10 AMBULANCE SERVICES			31,207		1,169,453		1,169,453
069 20 CMHC							
069 30 OUTPATIENT PHYSICAL THERA							
069 40 OUTPATIENT OCCUPATIONAL T							
071 HOME HEALTH AGENCY				10,599	2,004,933		2,004,933
085 01 PANCREAS ACQUISITION							
085 02 INTESTINAL ACQUISITION							
085 03 ISLET CELL ACQUISITION							
095 SUBTOTALS	53,921		989,070	227,704	34,767,056		34,767,056
096 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP					20,139		20,139
100 PHYSICIANS' PRIVATE OFFIC					550,729		550,729
100 MARKETING					520,009		520,009
100 01 WOMEN'S HEALTH SERVICES					144,149		144,149
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	53,921		989,070	227,704	36,002,082		36,002,082

Health Financial Systems		MCRIF32	FOR DECATUR CO. MEMORIAL		IN LIEU OF FORM CMS-2552-96(7/2009)		
ALLOCATION OF NEW CAPITAL RELATED COSTS			I PROVIDER NO: I 15-1332 I	I PERIOD: I FROM 1/ 1/2010 I TO 12/31/2010	I PREPARED 5/31/2011 I WORKSHEET B I PART III		
COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS 0	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-MVBLE E 4	SUBTOTAL 4a	EMPLOYEE BENE FITS 5	ADMINISTRATIV E & GENERAL 6	MAINTENANCE & REPAIRS 7
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS		1,126	2,450	3,576	3,576		
006 ADMINISTRATIVE & GENERAL		146,756	319,335	466,091	437	466,528	
007 MAINTENANCE & REPAIRS		5,204	11,324	16,528	79	11,759	28,366
008 OPERATION OF PLANT		54,415	118,407	172,822	1	11,835	
009 LAUNDRY & LINEN SERVICE		5,630	12,252	17,882	10	1,591	
010 HOUSEKEEPING		4,168	9,070	13,238	72	10,920	2,742
011 DIETARY		10,729	23,346	34,075	20	3,982	145
012 CAFETERIA		2,502	5,445	7,947	49	6,479	1,302
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION		4,027	8,763	12,790	133	14,547	30
015 CENTRAL SERVICES & SUPPLY					5	575	
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY		20,281	44,132	64,413	90	11,480	844
018 SOCIAL SERVICE		1,869	4,067	5,936	23	2,610	90
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS		53,891	117,267	171,158	408	46,509	3,182
026 INTENSIVE CARE UNIT		5,153	11,214	16,367	62	7,090	362
033 NURSERY		2,972	6,466	9,438	28	3,198	838
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		42,196	91,819	134,015	186	22,770	2,459
039 DELIVERY ROOM & LABOR ROO		38,615	84,026	122,641	13	3,262	380
040 ANESTHESIOLOGY					77	3,250	
041 RADIOLOGY-DIAGNOSTIC		36,523	79,474	115,997	203	33,186	4,426
041 01 ULTRA SOUND					14	2,285	
044 LABORATORY		18,596	40,465	59,061	177	25,688	380
046 WHOLE BLOOD & PACKED RED						1,192	
046 30 BLOOD CLOTTING FACTORS AD							
049 RESPIRATORY THERAPY		6,846	14,898	21,744	101	11,834	151
050 PHYSICAL THERAPY		10,760	23,414	34,174	97	10,962	783
051 OCCUPATIONAL THERAPY		6,006	13,068	19,074	30	3,477	
052 SPEECH PATHOLOGY		5,630	12,252	17,882	50	6,071	60
053 ELECTROCARDIOLOGY		3,050	6,636	9,686	18	2,895	
055 MEDICAL SUPPLIES CHARGED		9,540	20,760	30,300		35,366	
055 30 IMPL. DEV. CHARGED TO PAT						283	
056 DRUGS CHARGED TO PATIENTS		9,009	19,603	28,612	127	43,750	211
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC		7,765	16,897	24,662	92	6,840	
060 01 ONCOLOGY		3,480	7,572	11,052	37	5,736	301
060 02 OUTPATIENT CLINIC		24,715	53,780	78,495	17	3,148	1,989
060 03 PROVIDER BASED CLINIC - T		65,038	141,524	206,562	60	12,187	2,489
060 04 PROVIDER BASED CLINIC - D		24,633	53,601	78,234	130	15,921	591
060 05 PROVIDER BASED CLINIC - W		4,692	10,210	14,902	16	2,204	241
060 06 CLINIC		9,423	20,505	29,928	17	2,942	783
061 EMERGENCY		23,069	50,198	73,267	375	29,741	452
062 OBSERVATION BEDS (NON-DIS							
063 50 RHC							
063 60 FQHC							
065 OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES		14,076	30,629	44,705	105	13,929	121
069 10 CMHC							
069 20 OUTPATIENT PHYSICAL THERA							
069 30 OUTPATIENT OCCUPATIONAL T							
069 40 OUTPATIENT SPEECH PATHOLO							
071 HOME HEALTH AGENCY		10,275	22,359	32,634	188	22,280	2,290
071 SPEC PURPOSE COST CENTERS							
085 01 PANCREAS ACQUISITION							
085 02 INTESTINAL ACQUISITION							
085 03 ISLET CELL ACQUISITION							
095 SUBTOTALS		692,660	1,507,228	2,199,888	3,547	453,774	27,642
095 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP		2,639	5,743	8,382		207	
098 PHYSICIANS' PRIVATE OFFIC		91,462	199,022	290,484		4,448	
100 MARKETING		688	1,497	2,185	24	6,384	603
100 01 WOMEN'S HEALTH SERVICES		684	1,489	2,173	5	1,715	121
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		788,133	1,714,979	2,503,112	3,576	466,528	28,366

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION
	8	9	10	11	12	13	14
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT	184,658						
010 LAUNDRY & LINEN SERVICE	1,791	21,274					
011 HOUSEKEEPING	1,326	1,988	30,286				
012 DIETARY	3,412	91		41,725			
013 CAFETERIA	796		825		17,398		
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION	1,281		134		618		29,533
016 CENTRAL SERVICES & SUPPLY					69		186
017 PHARMACY							
018 MEDICAL RECORDS & LIBRARY	6,450		269		1,091		
025 SOCIAL SERVICE	594		43		138		372
026 INPAT ROUTINE SRVC CNTRS							
037 ADULTS & PEDIATRICS	17,139	8,203	9,371	40,426	2,874		7,783
039 INTENSIVE CARE UNIT	1,639	268	539	1,299	324		877
040 NURSERY	945	438	928		164		442
041 OTHER LONG TERM CARE							
042 ANCILLARY SRVC COST CNTRS							
043 OPERATING ROOM	13,420	3,350	87		1,338		3,617
044 DELIVERY ROOM & LABOR ROO	12,281	596	1,197		74		201
045 ANESTHESIOLOGY					54		
046 RADIOLOGY-DIAGNOSTIC	11,615	1,710	1,794		1,431		
047 01 ULTRA SOUND							
048 LABORATORY	5,914		1,172		1,330		94
049 WHOLE BLOOD & PACKED RED							
050 30 BLOOD CLOTTING FACTORS AD							
051 RESPIRATORY THERAPY	2,177	176	603		662		1,789
052 PHYSICAL THERAPY	3,422	1,142	519		663		1,793
053 OCCUPATIONAL THERAPY	1,910		13		167		451
054 SPEECH PATHOLOGY	1,791		193		310		837
055 ELECTROCARDIOLOGY	970	197	682				
056 MEDICAL SUPPLIES CHARGED	3,034						
060 30 IMPL. DEV. CHARGED TO PAT							
061 DRUGS CHARGED TO PATIENTS	2,865		2,652		781		2,111
062 OUTPAT SERVICE COST CNTRS							
063 CLINIC	2,470				70		639
064 01 ONCOLOGY	1,107	84	587		275		744
065 02 OUTPATIENT CLINIC	7,860	106	1,282		183		494
066 03 PROVIDER BASED CLINIC - T	20,684	124					
067 04 PROVIDER BASED CLINIC - D	7,834	18	2,205		577		
068 05 PROVIDER BASED CLINIC - W	1,492						
069 06 CLINIC	2,997	32	182		107		288
070 EMERGENCY	7,337	2,352	2,995		1,421		3,059
071 OBSERVATION BEDS (NON-DIS							
072 50 RHC							
073 60 FQHC							
074 OTHER REIMBURS COST CNTRS							
075 AMBULANCE SERVICES	4,477	322			1,075		
076 10 CMHC							
077 20 OUTPATIENT PHYSICAL THERA							
078 30 OUTPATIENT OCCUPATIONAL T							
079 40 OUTPATIENT SPEECH PATHOLO							
080 HOME HEALTH AGENCY	3,268				1,339		3,622
081 SPEC PURPOSE COST CENTERS							
082 01 PANCREAS ACQUISITION							
083 02 INTESTINAL ACQUISITION							
084 03 ISLET CELL ACQUISITION							
085 SUBTOTALS	154,298	21,197	28,272	41,725	17,135		29,399
086 NONREIMBURS COST CENTERS							
087 GIFT, FLOWER, COFFEE SHOP	839						
088 PHYSICIANS' PRIVATE OFFIC	29,084	77	2,014				
089 MARKETING	219				213		
090 01 WOMEN'S HEALTH SERVICES	218				50		134
091 CROSS FOOT ADJUSTMENTS							
092 NEGATIVE COST CENTER							
093 TOTAL	184,658	21,274	30,286	41,725	17,398		29,533

ALLOCATION OF NEW CAPITAL RELATED COSTS

	COST CENTER DESCRIPTION	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		15	16	17	18	25	26	27
003	GENERAL SERVICE COST CNTR							
004	NEW CAP REL COSTS-BLDG &							
005	NEW CAP REL COSTS-MVBLE E							
006	EMPLOYEE BENEFITS							
007	ADMINISTRATIVE & GENERAL							
008	MAINTENANCE & REPAIRS							
009	OPERATION OF PLANT							
010	LAUNDRY & LINEN SERVICE							
011	HOUSEKEEPING							
012	DIETARY							
013	CAFETERIA							
014	MAINTENANCE OF PERSONNEL							
015	NURSING ADMINISTRATION							
016	CENTRAL SERVICES & SUPPLY	835						
017	PHARMACY							
018	MEDICAL RECORDS & LIBRARY			84,637				
018	SOCIAL SERVICE				9,806			
025	INPAT ROUTINE SRVC CNTRS							
026	ADULTS & PEDIATRICS			3,552	9,144	319,749		319,749
033	INTENSIVE CARE UNIT			278		29,105		29,105
036	NURSERY			610		17,029		17,029
036	OTHER LONG TERM CARE							
037	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM			8,469		189,711		189,711
039	DELIVERY ROOM & LABOR ROO			461		141,106		141,106
040	ANESTHESIOLOGY			522		3,903		3,903
041	RADIOLOGY-DIAGNOSTIC			18,942		189,304		189,304
041 01	ULTRA SOUND			2,050		4,349		4,349
044	LABORATORY			13,898		107,714		107,714
046	WHOLE BLOOD & PACKED RED			521		1,713		1,713
046 30	BLOOD CLOTTING FACTORS AD							
049	RESPIRATORY THERAPY			2,150		41,387		41,387
050	PHYSICAL THERAPY			2,337		55,892		55,892
051	OCCUPATIONAL THERAPY			600		25,722		25,722
052	SPEECH PATHOLOGY			797		27,991		27,991
053	ELECTROCARDIOLOGY			2,947		17,395		17,395
055	MEDICAL SUPPLIES CHARGED	835		4,718		74,253		74,253
055 30	IMPL. DEV. CHARGED TO PAT			30		313		313
056	DRUGS CHARGED TO PATIENTS			9,775		90,884		90,884
060	OUTPAT SERVICE COST CNTRS							
060	CLINIC			298		35,071		35,071
060 01	ONCOLOGY			293	29	20,245		20,245
060 02	OUTPATIENT CLINIC			277		93,851		93,851
060 03	PROVIDER BASED CLINIC - T			1,093		243,199		243,199
060 04	PROVIDER BASED CLINIC - D			643		106,153		106,153
060 05	PROVIDER BASED CLINIC - W			108		18,963		18,963
060 06	CLINIC			158		37,434		37,434
061	EMERGENCY			6,439	177	127,615		127,615
062	OBSERVATION BEDS (NON-DIS							
063 50	RHC							
063 60	FQHC							
065	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES			2,671		67,405		67,405
069 10	CMHC							
069 20	OUTPATIENT PHYSICAL THERA							
069 30	OUTPATIENT OCCUPATIONAL T							
069 40	OUTPATIENT SPEECH PATHOLO							
071	HOME HEALTH AGENCY				456	66,077		66,077
085	SPEC PURPOSE COST CENTERS							
085 01	PANCREAS ACQUISITION							
085 02	INTESTINAL ACQUISITION							
085 03	ISLET CELL ACQUISITION							
095	SUBTOTALS	835		84,637	9,806	2,153,533		2,153,533
096	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP					9,428		9,428
098	PHYSICIANS' PRIVATE OFFIC					326,107		326,107
100	MARKETING					9,628		9,628
100 01	WOMEN'S HEALTH SERVICES					4,416		4,416
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	835		84,637	9,806	2,503,112		2,503,112

COST ALLOCATION - STATISTICAL BASIS

	COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	RECONCILIATION	ADMINISTRATIV	MAINTENANCE &
		OSTS-BLDG &	OSTS-MVBLE	FITS		E & GENERAL	REPAIRS
		(SQUARE FEE T	(SQUARE FEE T	(GROSS SALARIES)		(ACCUM. COST)	(TIME SPENT)
		3	4	5	6a.00	6	7
	GENERAL SERVICE COST						
003	NEW CAP REL COSTS-BLD	201,570					
004	NEW CAP REL COSTS-MVB		201,570				
005	EMPLOYEE BENEFITS	288	288	19,454,260			
006	ADMINISTRATIVE & GENE	37,533	37,533	2,394,899	-5,534,332	30,467,750	
007	MAINTENANCE & REPAIRS	1,331	1,331	431,053		767,954	4,707
008	OPERATION OF PLANT	13,917	13,917	3,732		772,924	
009	LAUNDRY & LINEN SERVI	1,440	1,440	54,996		103,922	
010	HOUSEKEEPING	1,066	1,066	389,426		713,159	455
011	DIETARY	2,744	2,744	109,164		260,040	24
012	CAFETERIA	640	640	266,095		423,158	216
013	MAINTENANCE OF PERSON						
014	NURSING ADMINISTRATIO	1,030	1,030	721,468		950,043	5
015	CENTRAL SERVICES & SU			28,230		37,583	
016	PHARMACY						
017	MEDICAL RECORDS & LIB	5,187	5,187	488,311		749,723	140
018	SOCIAL SERVICE	478	478	127,459		170,485	15
	INPAT ROUTINE SRVC CN						
025	ADULTS & PEDIATRICS	13,783	13,783	2,218,258		3,037,111	528
026	INTENSIVE CARE UNIT	1,318	1,318	339,202		463,031	60
033	NURSERY	760	760	151,199		208,825	139
036	OTHER LONG TERM CARE						
	ANCILLARY SRVC COST C						
037	OPERATING ROOM	10,792	10,792	1,013,371		1,487,050	408
039	DELIVERY ROOM & LABOR	9,876	9,876	68,531		213,013	63
040	ANESTHESIOLOGY			417,864		212,252	
041	RADIOLOGY-DIAGNOSTIC	9,341	9,341	1,103,596		2,167,293	735
041	01 ULTRA SOUND			77,217		149,236	
044	LABORATORY	4,756	4,756	960,695		1,677,632	63
046	WHOLE BLOOD & PACKED					77,862	
046	30 BLOOD CLOTTING FACTOR						
049	RESPIRATORY THERAPY	1,751	1,751	547,493		772,851	25
050	PHYSICAL THERAPY	2,752	2,752	524,949		715,910	130
051	OCCUPATIONAL THERAPY	1,536	1,536	160,328		227,045	
052	SPEECH PATHOLOGY	1,440	1,440	272,160		396,478	10
053	ELECTROCARDIOLOGY	780	780	97,376		189,038	
055	MEDICAL SUPPLIES CHAR	2,440	2,440			2,309,690	
055	30 IMPL. DEV. CHARGED TO					18,510	
056	DRUGS CHARGED TO PATI	2,304	2,304	691,225		2,857,204	35
	OUTPAT SERVICE COST C						
060	CLINIC	1,986	1,986	502,509		446,715	
060	01 ONCOLOGY	890	890	203,250		374,636	50
060	02 OUTPATIENT CLINIC	6,321	6,321	93,105		205,594	330
060	03 PROVIDER BASED CLINIC	16,634	16,634	326,375		795,905	413
060	04 PROVIDER BASED CLINIC	6,300	6,300	705,901		1,039,799	98
060	05 PROVIDER BASED CLINIC	1,200	1,200	89,621		143,954	40
060	06 CLINIC	2,410	2,410	91,156		192,124	130
061	EMERGENCY	5,900	5,900	2,037,966		1,942,305	75
062	OBSERVATION BEDS (NON						
063	50 RHC						
063	60 FQHC						
	OTHER REIMBURS COST C						
065	AMBULANCE SERVICES	3,600	3,600	570,948		909,697	20
069	10 CMHC						
069	20 OUTPATIENT PHYSICAL T						
069	30 OUTPATIENT OCCUPATION						
069	40 OUTPATIENT SPEECH PAT						
071	HOME HEALTH AGENCY	2,628	2,628	1,019,781		1,455,048	380
	SPEC PURPOSE COST CEN						
085	01 PANCREAS ACQUISITION						
085	02 INTESTINAL ACQUISITIO						
085	03 ISLET CELL ACQUISITIO						
095	SUBTOTALS	177,152	177,152	19,298,909	-5,534,332	29,634,799	4,587
	NONREIMBURS COST CENT						
096	GIFT, FLOWER, COFFEE	675	675			13,530	
098	PHYSICIANS' PRIVATE O	23,392	23,392			290,484	
100	MARKETING	176	176	128,592		416,928	100
100	01 WOMEN'S HEALTH SERVIC	175	175	26,759		112,009	20
101	CROSS FOOT ADJUSTMENT						
102	NEGATIVE COST CENTER						
103	COST TO BE ALLOCATED	788,133	1,714,979	5,244,873		5,534,332	907,450
	(WRKSHT B, PART I)						
104	UNIT COST MULTIPLIER	3.909972		.269600		.181646	
	(WRKSHT B, PT I)		8.508106				192.787338
105	COST TO BE ALLOCATED						
	(WRKSHT B, PART II)						
106	UNIT COST MULTIPLIER						
	(WRKSHT B, PT II)						
107	COST TO BE ALLOCATED			3,576		466,528	28,366
	(WRKSHT B, PART III)						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	RECONCIL- IATION	ADMINISTRATIV	MAINTENANCE &
	OSTS-BLDG &	OSTS-MVBLE E	FITS		E & GENERAL	REPAIRS
	(SQUARE FEE T	(SQUARE FEE T	(GROSS SALARIES)		(ACCUM. COST)	(TIME SPENT)
	3	4	5	6a.00	6	7
108 NONREIMBURS COST CENT UNIT COST MULTIPLIER (WRKSHT B, PT III)			.000184		.015312	6.026344

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NRSNG HOURS)
	8	9	10	11	12	13	14
003 GENERAL SERVICE COST							
004 NEW CAP REL COSTS-BLD							
005 NEW CAP REL COSTS-MVB							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT	148,501						
010 LAUNDRY & LINEN SERVICE	1,440	220,890					
011 HOUSEKEEPING	1,066	20,645	135,141				
012 DIETARY	2,744	941		14,323			
013 CAFETERIA	640		3,680		536,793		
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION	1,030		600		19,059		336,967
016 CENTRAL SERVICES & SUPPLY					2,118		2,118
017 PHARMACY							
018 MEDICAL RECORDS & LIBRARY	5,187		1,200		33,668		
025 SOCIAL SERVICE	478		190		4,250		4,250
026 INPUT ROUTINE SERVICE CENTER							
033 ADULTS & PEDIATRICS	13,783	85,153	41,812	13,877	88,791		88,791
036 INTENSIVE CARE UNIT	1,318	2,779	2,405	446	10,005		10,005
040 NURSERY	760	4,553	4,140		5,048		5,048
041 OTHER LONG TERM CARE							
044 ANCILLARY SERVICE COST CENTER							
046 OPERATING ROOM	10,792	34,787	390		41,268		41,268
049 DELIVERY ROOM & LABOR	9,876	6,191	5,339		2,288		2,288
051 ANESTHESIOLOGY					1,669		
052 RADIOLOGY-DIAGNOSTIC	9,341	17,752	8,005		44,144		
055 01 ULTRA SOUND							
056 LABORATORY	4,756		5,230		41,032		1,078
060 WHOLE BLOOD & PACKED							
063 30 BLOOD CLOTTING FACTOR							
065 RESPIRATORY THERAPY	1,751	1,831	2,692		20,411		20,411
069 PHYSICAL THERAPY	2,752	11,859	2,315		20,462		20,462
071 OCCUPATIONAL THERAPY	1,536		60		5,149		5,149
075 SPEECH PATHOLOGY	1,440		860		9,552		9,552
080 ELECTROCARDIOLOGY	780	2,044	3,045				
085 MEDICAL SUPPLIES CHARACTER	2,440						
090 30 IMPL. DEV. CHARGED TO PATIENT							
095 DRUGS CHARGED TO PATIENT	2,304		11,835		24,087		24,087
100 OUTPAT SERVICE COST CENTER							
105 CLINIC	1,986				2,160		7,296
110 01 ONCOLOGY	890	872	2,620		8,489		8,489
115 02 OUTPATIENT CLINIC	6,321	1,105	5,720		5,631		5,631
120 03 PROVIDER BASED CLINIC	16,634	1,288					
125 04 PROVIDER BASED CLINIC	6,300	190	9,840		17,799		
130 05 PROVIDER BASED CLINIC	1,200						
135 06 CLINIC	2,410	334	810		3,290		3,290
140 EMERGENCY	5,900	24,419	13,365		43,837		34,903
145 OBSERVATION BEDS (NON RHC)							
150 50 RHC							
155 60 FQHC							
160 OTHER REIMBURS COST CENTER							
165 AMBULANCE SERVICES	3,600	3,348			33,172		
170 10 CMHC							
175 20 OUTPATIENT PHYSICAL THERAPY							
180 30 OUTPATIENT OCCUPATION							
185 40 OUTPATIENT SPEECH PAT							
190 HOME HEALTH AGENCY	2,628				41,323		41,323
195 SPEC PURPOSE COST CENTER							
200 01 PANCREAS ACQUISITION							
205 02 INTESTINAL ACQUISITION							
210 03 ISLET CELL ACQUISITION							
215 SUBTOTALS	124,083	220,091	126,153	14,323	528,702		335,439
220 NONREIMBURS COST CENTER							
225 GIFT, FLOWER, COFFEE	675						
230 PHYSICIANS' PRIVATE OFFICE	23,392	799	8,988				
235 MARKETING	176				6,563		
240 01 WOMEN'S HEALTH SERVICE	175				1,528		1,528
245 CROSS FOOT ADJUSTMENT							
250 NEGATIVE COST CENTER							
255 COST TO BE ALLOCATED (WRKSHT B, PART I)	913,323	131,655	949,280	329,339	571,451		1,154,419
260 UNIT COST MULTIPLIER (WRKSHT B, PT I)		.596021		22.993716			
265 COST TO BE ALLOCATED (WRKSHT B, PART II)	6.150282		7.024367		1.064565		3.425911
270 UNIT COST MULTIPLIER (WRKSHT B, PT II)							
275 COST TO BE ALLOCATED (WRKSHT B, PART III)	184,658	21,274	30,286	41,725	17,398		29,533

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION
		(SQUARE FEET)	(POUNDS OF LAUNDRY)	(HOURS OF SERVICE)	(MEALS SERVED)	(HOURS)	(NUMBER HOUSED)	(NRSING HOURS)
		8	9	10	11	12	13	14
108	NONREIMBURS COST CENT UNIT COST MULTIPLIER (WRKSH T B, PT III)	1.243480	.096310	.224107	2.913147	.032411		.087644

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET B-1
 I TO 12/31/2010 I

	COST CENTER DESCRIPTION	CENTRAL SERVI PHARMACY CES & SUPPLY		MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E
		(COSTED REQUIS. 15	(COSTED)REQUIS. 16	(GROSS)ARGES 17	CH(TIME SPENT) 18
	GENERAL SERVICE COST				
003	NEW CAP REL COSTS-BLD				
004	NEW CAP REL COSTS-MVB				
005	EMPLOYEE BENEFITS				
006	ADMINISTRATIVE & GENE				
007	MAINTENANCE & REPAIRS				
008	OPERATION OF PLANT				
009	LAUNDRY & LINEN SERVI				
010	HOUSEKEEPING				
011	DIETARY				
012	CAFETERIA				
013	MAINTENANCE OF PERSON				
014	NURSING ADMINISTRATIO				
015	CENTRAL SERVICES & SU	100			
016	PHARMACY		100		
017	MEDICAL RECORDS & LIB			69,661,096	
018	SOCIAL SERVICE				1,332
	INPAT ROUTINE SRVC CN				
025	ADULTS & PEDIATRICS			2,923,534	1,242
026	INTENSIVE CARE UNIT			229,028	
033	NURSERY			502,276	
036	OTHER LONG TERM CARE				
	ANCILLARY SRVC COST C				
037	OPERATING ROOM			6,970,106	
039	DELIVERY ROOM & LABOR			379,589	
040	ANESTHESIOLOGY			429,996	
041	RADIOLOGY-DIAGNOSTIC			15,591,046	
041 01	ULTRA SOUND			1,687,034	
044	LABORATORY			11,438,885	
046	WHOLE BLOOD & PACKED			428,428	
046 30	BLOOD CLOTTING FACTOR				
049	RESPIRATORY THERAPY			1,769,752	
050	PHYSICAL THERAPY			1,923,522	
051	OCCUPATIONAL THERAPY			493,513	
052	SPEECH PATHOLOGY			655,912	
053	ELECTROCARDIOLOGY			2,425,559	
055	MEDICAL SUPPLIES CHAR	100		3,882,913	
055 30	IMPL. DEV. CHARGED TO			24,908	
056	DRUGS CHARGED TO PATI		100	8,045,137	
	OUTPAT SERVICE COST C				
060	CLINIC			245,325	
060 01	ONCOLOGY			240,751	4
060 02	OUTPATIENT CLINIC			227,952	
060 03	PROVIDER BASED CLINIC			899,570	
060 04	PROVIDER BASED CLINIC			529,270	
060 05	PROVIDER BASED CLINIC			89,142	
060 06	CLINIC			129,995	
061	EMERGENCY			5,299,972	24
062	OBSERVATION BEDS (NON				
063 50	RHC				
063 60	FQHC				
	OTHER REIMBURS COST C				
065	AMBULANCE SERVICES			2,197,981	
069 10	CMHC				
069 20	OUTPATIENT PHYSICAL T				
069 30	OUTPATIENT OCCUPATION				
069 40	OUTPATIENT SPEECH PAT				
071	HOME HEALTH AGENCY				62
	SPEC PURPOSE COST CEN				
085 01	PANCREAS ACQUISITION				
085 02	INTESTINAL ACQUISITIO				
085 03	ISLET CELL ACQUISITIO				
095	SUBTOTALS	100	100	69,661,096	1,332
	NONREIMBURS COST CENT				
096	GIFT, FLOWER, COFFEE				
098	PHYSICIANS' PRIVATE O				
100	MARKETING				
100 01	WOMEN'S HEALTH SERVIC				
101	CROSS FOOT ADJUSTMENT				
102	NEGATIVE COST CENTER				
103	COST TO BE ALLOCATED	53,921		989,070	227,704
	(PER WRKSHT B, PART				
104	UNIT COST MULTIPLIER				170.948949
	(WRKSHT B, PT I)	539.210000		.014198	
105	COST TO BE ALLOCATED				
	(PER WRKSHT B, PART				
106	UNIT COST MULTIPLIER				
	(WRKSHT B, PT II)				
107	COST TO BE ALLOCATED	835		84,637	9,806
	(PER WRKSHT B, PART				

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

	COST CENTER DESCRIPTION	CENTRAL SERVI PHARMACY CES & SUPPLY		MEDICAL RECOR SOCIAL SERVIC DS & LIBRARY E	
		(COSTED REQUIS.	(COSTED)REQUIS.	(GROSS)ARGES	CH(TIME SPENT)
		15	16	17	18
108	NONREIMBURS COST CENT UNIT COST MULTIPLIER (WRKSHT B, PT III)	8.350000		.001215	7.361862

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET C
 I I TO 12/31/2010 I PART I

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
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	5,091,418		5,091,418		5,091,418
26	INTENSIVE CARE UNIT	643,796		643,796		643,796
33	NURSERY	339,822		339,822		339,822
36	OTHER LONG TERM CARE ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	2,209,946		2,209,946		2,209,946
39	DELIVERY ROOM & LABOR ROO	381,448		381,448		381,448
40	ANESTHESIOLOGY	258,689		258,689		258,689
41	RADIOLOGY-DIAGNOSTIC	3,095,309		3,095,309		3,095,309
41 01	ULTRA SOUND	200,297		200,297		200,297
44	LABORATORY	2,270,284		2,270,284		2,270,284
46	WHOLE BLOOD & PACKED RED	98,088		98,088		98,088
46 30	BLOOD CLOTTING FACTORS AD					
49	RESPIRATORY THERAPY	1,065,608		1,065,608		1,065,608
50	PHYSICAL THERAPY	1,030,463		1,030,463		1,030,463
51	OCCUPATIONAL THERAPY	308,283		308,283		308,283
52	SPEECH PATHOLOGY	537,528		537,528		537,528
53	ELECTROCARDIOLOGY	285,218		285,218		285,218
55	MEDICAL SUPPLIES CHARGED	2,853,294		2,853,294		2,853,294
55 30	IMPL. DEV. CHARGED TO PAT	22,226		22,226		22,226
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	3,702,642		3,702,642		3,702,642
60	CLINIC	570,850		570,850		570,850
60 01	ONCOLOGY	518,946		518,946		518,946
60 02	OUTPATIENT CLINIC	414,795		414,795		414,795
60 03	PROVIDER BASED CLINIC - T	1,135,943		1,135,943		1,135,943
60 04	PROVIDER BASED CLINIC - D	1,382,010		1,382,010		1,382,010
60 05	PROVIDER BASED CLINIC - W	186,460		186,460		186,460
60 06	CLINIC	289,415		289,415		289,415
61	EMERGENCY	2,699,892		2,699,892		2,699,892
62	OBSERVATION BEDS (NON-DIS	1,340,186		1,340,186		1,340,186
63 50	RHC					
63 60	FQHC					
65	OTHER REIMBURS COST CNTRS AMBULANCE SERVICES	1,169,453		1,169,453		1,169,453
101	SUBTOTAL	34,102,309		34,102,309		34,102,309
102	LESS OBSERVATION BEDS	1,340,186		1,340,186		1,340,186
103	TOTAL	32,762,123		32,762,123		32,762,123

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET C
 I I TO 12/31/2010 I PART I

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						
25	ADULTS & PEDIATRICS	2,923,534		2,923,534			
26	INTENSIVE CARE UNIT	229,028		229,028			
33	NURSERY	502,276		502,276			
36	OTHER LONG TERM CARE						
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,644,972	5,325,134	6,970,106	.317061	.317061	.317061
39	DELIVERY ROOM & LABOR ROO	284,786	94,803	379,589	1.004897	1.004897	1.004897
40	ANESTHESIOLOGY	120,416	309,580	429,996	.601608	.601608	.601608
41	RADIOLOGY-DIAGNOSTIC	1,139,215	14,451,831	15,591,046	.198531	.198531	.198531
41	01 ULTRA SOUND	120,696	1,566,338	1,687,034	.118727	.118727	.118727
44	LABORATORY	1,522,708	9,916,177	11,438,885	.198471	.198471	.198471
46	WHOLE BLOOD & PACKED RED	194,062	234,366	428,428	.228949	.228949	.228949
46	30 BLOOD CLOTTING FACTORS AD						
49	RESPIRATORY THERAPY	1,108,818	660,934	1,769,752	.602123	.602123	.602123
50	PHYSICAL THERAPY	246,267	1,677,255	1,923,522	.535717	.535717	.535717
51	OCCUPATIONAL THERAPY	174,152	319,361	493,513	.624670	.624670	.624670
52	SPEECH PATHOLOGY	52,148	603,764	655,912	.819512	.819512	.819512
53	ELECTROCARDIOLOGY	189,093	2,236,466	2,425,559	.117589	.117589	.117589
55	MEDICAL SUPPLIES CHARGED	2,054,489	1,828,424	3,882,913	.734833	.734833	.734833
55	30 IMPL. DEV. CHARGED TO PAT	2,256	22,652	24,908	.892324	.892324	.892324
56	DRUGS CHARGED TO PATIENTS	2,726,118	5,319,019	8,045,137	.460234	.460234	.460234
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		245,325	245,325	2.326913	2.326913	2.326913
60	01 ONCOLOGY		240,751	240,751	2.155530	2.155530	2.155530
60	02 OUTPATIENT CLINIC	164,764	63,188	227,952	1.819659	1.819659	1.819659
60	03 PROVIDER BASED CLINIC - T	3,516	896,054	899,570	1.262762	1.262762	1.262762
60	04 PROVIDER BASED CLINIC - D		529,270	529,270	2.611163	2.611163	2.611163
60	05 PROVIDER BASED CLINIC - W		89,142	89,142	2.091719	2.091719	2.091719
60	06 CLINIC		129,995	129,995	2.226355	2.226355	2.226355
61	EMERGENCY	116,532	5,183,440	5,299,972	.509416	.509416	.509416
62	OBSERVATION BEDS (NON-DIS		1,085,750	1,085,750	1.234341	1.234341	1.234341
63	50 RHC						
63	60 FQHC						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		2,197,981	2,197,981	.532058	.532058	.532058
101	SUBTOTAL	15,519,846	55,227,000	70,746,846			
102	LESS OBSERVATION BEDS						
103	TOTAL	15,519,846	55,227,000	70,746,846			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
I 15-1332 I FROM 1/ 1/2010 I WORKSHEET C
I I TO 12/31/2010 I PART I

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
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	5,091,418		5,091,418		5,091,418
26	INTENSIVE CARE UNIT	643,796		643,796		643,796
33	NURSERY	339,822		339,822		339,822
36	OTHER LONG TERM CARE ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	2,209,946		2,209,946		2,209,946
39	DELIVERY ROOM & LABOR ROO	381,448		381,448		381,448
40	ANESTHESIOLOGY	258,689		258,689		258,689
41	RADIOLOGY-DIAGNOSTIC	3,095,309		3,095,309		3,095,309
41 01	ULTRA SOUND	200,297		200,297		200,297
44	LABORATORY	2,270,284		2,270,284		2,270,284
46	WHOLE BLOOD & PACKED RED	98,088		98,088		98,088
46 30	BLOOD CLOTTING FACTORS AD					
49	RESPIRATORY THERAPY	1,065,608		1,065,608		1,065,608
50	PHYSICAL THERAPY	1,030,463		1,030,463		1,030,463
51	OCCUPATIONAL THERAPY	308,283		308,283		308,283
52	SPEECH PATHOLOGY	537,528		537,528		537,528
53	ELECTROCARDIOLOGY	285,218		285,218		285,218
55	MEDICAL SUPPLIES CHARGED	2,853,294		2,853,294		2,853,294
55 30	IMPL. DEV. CHARGED TO PAT	22,226		22,226		22,226
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	3,702,642		3,702,642		3,702,642
60	CLINIC	570,850		570,850		570,850
60 01	ONCOLOGY	518,946		518,946		518,946
60 02	OUTPATIENT CLINIC	414,795		414,795		414,795
60 03	PROVIDER BASED CLINIC - T	1,135,943		1,135,943		1,135,943
60 04	PROVIDER BASED CLINIC - D	1,382,010		1,382,010		1,382,010
60 05	PROVIDER BASED CLINIC - W	186,460		186,460		186,460
60 06	CLINIC	289,415		289,415		289,415
61	EMERGENCY	2,699,892		2,699,892		2,699,892
62	OBSERVATION BEDS (NON-DIS	1,340,186		1,340,186		1,340,186
63 50	RHC					
63 60	FQHC					
65	OTHER REIMBURS COST CNTRS AMBULANCE SERVICES	1,169,453		1,169,453		1,169,453
101	SUBTOTAL	34,102,309		34,102,309		34,102,309
102	LESS OBSERVATION BEDS	1,340,186		1,340,186		1,340,186
103	TOTAL	32,762,123		32,762,123		32,762,123

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
I 15-1332 I FROM 1/ 1/2010 I WORKSHEET C
I I TO 12/31/2010 I PART I

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						
25	ADULTS & PEDIATRICS	2,923,534		2,923,534			
26	INTENSIVE CARE UNIT	229,028		229,028			
33	NURSERY	502,276		502,276			
36	OTHER LONG TERM CARE						
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,644,972	5,325,134	6,970,106	.317061	.317061	.317061
39	DELIVERY ROOM & LABOR ROO	284,786	94,803	379,589	1.004897	1.004897	1.004897
40	ANESTHESIOLOGY	120,416	309,580	429,996	.601608	.601608	.601608
41	RADIOLOGY-DIAGNOSTIC	1,139,215	14,451,831	15,591,046	.198531	.198531	.198531
41 01	ULTRA SOUND	120,696	1,566,338	1,687,034	.118727	.118727	.118727
44	LABORATORY	1,522,708	9,916,177	11,438,885	.198471	.198471	.198471
46	WHOLE BLOOD & PACKED RED	194,062	234,366	428,428	.228949	.228949	.228949
46 30	BLOOD CLOTTING FACTORS AD						
49	RESPIRATORY THERAPY	1,108,818	660,934	1,769,752	.602123	.602123	.602123
50	PHYSICAL THERAPY	246,267	1,677,255	1,923,522	.535717	.535717	.535717
51	OCCUPATIONAL THERAPY	174,152	319,361	493,513	.624670	.624670	.624670
52	SPEECH PATHOLOGY	52,148	603,764	655,912	.819512	.819512	.819512
53	ELECTROCARDIOLOGY	189,093	2,236,466	2,425,559	.117589	.117589	.117589
55	MEDICAL SUPPLIES CHARGED	2,054,489	1,828,424	3,882,913	.734833	.734833	.734833
55 30	IMPL. DEV. CHARGED TO PAT	2,256	22,652	24,908	.892324	.892324	.892324
56	DRUGS CHARGED TO PATIENTS	2,726,118	5,319,019	8,045,137	.460234	.460234	.460234
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		245,325	245,325	2.326913	2.326913	2.326913
60 01	ONCOLOGY		240,751	240,751	2.155530	2.155530	2.155530
60 02	OUTPATIENT CLINIC	164,764	63,188	227,952	1.819659	1.819659	1.819659
60 03	PROVIDER BASED CLINIC - T	3,516	896,054	899,570	1.262762	1.262762	1.262762
60 04	PROVIDER BASED CLINIC - D		529,270	529,270	2.611163	2.611163	2.611163
60 05	PROVIDER BASED CLINIC - W		89,142	89,142	2.091719	2.091719	2.091719
60 06	CLINIC		129,995	129,995	2.226355	2.226355	2.226355
61	EMERGENCY	116,532	5,183,440	5,299,972	.509416	.509416	.509416
62	OBSERVATION BEDS (NON-DIS		1,085,750	1,085,750	1.234341	1.234341	1.234341
63 50	RHC						
63 60	FQHC						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		2,197,981	2,197,981	.532058	.532058	.532058
101	SUBTOTAL	15,519,846	55,227,000	70,746,846			
102	LESS OBSERVATION BEDS						
103	TOTAL	15,519,846	55,227,000	70,746,846			

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 COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	2,209,946	189,711	2,020,235			2,209,946
39	DELIVERY ROOM & LABOR ROO	381,448	141,106	240,342			381,448
40	ANESTHESIOLOGY	258,689	3,903	254,786			258,689
41	RADIOLOGY-DIAGNOSTIC	3,095,309	189,304	2,906,005			3,095,309
41 01	ULTRA SOUND	200,297	4,349	195,948			200,297
44	LABORATORY	2,270,284	107,714	2,162,570			2,270,284
46	WHOLE BLOOD & PACKED RED	98,088	1,713	96,375			98,088
46 30	BLOOD CLOTTING FACTORS AD						
49	RESPIRATORY THERAPY	1,065,608	41,387	1,024,221			1,065,608
50	PHYSICAL THERAPY	1,030,463	55,892	974,571			1,030,463
51	OCCUPATIONAL THERAPY	308,283	25,722	282,561			308,283
52	SPEECH PATHOLOGY	537,528	27,991	509,537			537,528
53	ELECTROCARDIOLOGY	285,218	17,395	267,823			285,218
55	MEDICAL SUPPLIES CHARGED	2,853,294	74,253	2,779,041			2,853,294
55 30	IMPL. DEV. CHARGED TO PAT	22,226	313	21,913			22,226
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	3,702,642	90,884	3,611,758			3,702,642
60	CLINIC	570,850	35,071	535,779			570,850
60 01	ONCOLOGY	518,946	20,245	498,701			518,946
60 02	OUTPATIENT CLINIC	414,795	93,851	320,944			414,795
60 03	PROVIDER BASED CLINIC - T	1,135,943	243,199	892,744			1,135,943
60 04	PROVIDER BASED CLINIC - D	1,382,010	106,153	1,275,857			1,382,010
60 05	PROVIDER BASED CLINIC - W	186,460	18,963	167,497			186,460
60 06	CLINIC	289,415	37,434	251,981			289,415
61	EMERGENCY	2,699,892	127,615	2,572,277			2,699,892
62	OBSERVATION BEDS (NON-DIS	1,340,186		1,340,186			1,340,186
63 50	RHC						
63 60	FQHC						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	1,169,453	67,405	1,102,048			1,169,453
101	SUBTOTAL	28,027,273	1,721,573	26,305,700			28,027,273
102	LESS OBSERVATION BEDS	1,340,186		1,340,186			1,340,186
103	TOTAL	26,687,087	1,721,573	24,965,514			26,687,087

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	6,970,106	.317061	.317061
39	DELIVERY ROOM & LABOR ROO	379,589	1.004897	1.004897
40	ANESTHESIOLOGY	429,996	.601608	.601608
41	RADIOLOGY-DIAGNOSTIC	15,591,046	.198531	.198531
41 01	ULTRA SOUND	1,687,034	.118727	.118727
44	LABORATORY	11,438,885	.198471	.198471
46	WHOLE BLOOD & PACKED RED	428,428	.228949	.228949
46 30	BLOOD CLOTTING FACTORS AD			
49	RESPIRATORY THERAPY	1,769,752	.602123	.602123
50	PHYSICAL THERAPY	1,923,522	.535717	.535717
51	OCCUPATIONAL THERAPY	493,513	.624670	.624670
52	SPEECH PATHOLOGY	655,912	.819512	.819512
53	ELECTROCARDIOLOGY	2,425,559	.117589	.117589
55	MEDICAL SUPPLIES CHARGED	3,882,913	.734833	.734833
55 30	IMPL. DEV. CHARGED TO PAT	24,908	.892324	.892324
56	DRUGS CHARGED TO PATIENTS	8,045,137	.460234	.460234
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	245,325	2.326913	2.326913
60 01	ONCOLOGY	240,751	2.155530	2.155530
60 02	OUTPATIENT CLINIC	227,952	1.819659	1.819659
60 03	PROVIDER BASED CLINIC - T	899,570	1.262762	1.262762
60 04	PROVIDER BASED CLINIC - D	529,270	2.611163	2.611163
60 05	PROVIDER BASED CLINIC - W	89,142	2.091719	2.091719
60 06	CLINIC	129,995	2.226355	2.226355
61	EMERGENCY	5,299,972	.509416	.509416
62	OBSERVATION BEDS (NON-DIS	1,085,750	1.234341	1.234341
63 50	RHC			
63 60	FQHC			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	2,197,981	.532058	.532058
101	SUBTOTAL	67,092,008		
102	LESS OBSERVATION BEDS	1,085,750		
103	TOTAL	66,006,258		

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 COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	2,209,946	189,711	2,020,235			2,209,946
39	DELIVERY ROOM & LABOR ROO	381,448	141,106	240,342			381,448
40	ANESTHESIOLOGY	258,689	3,903	254,786			258,689
41	RADIOLOGY-DIAGNOSTIC	3,095,309	189,304	2,906,005			3,095,309
41 01	ULTRA SOUND	200,297	4,349	195,948			200,297
44	LABORATORY	2,270,284	107,714	2,162,570			2,270,284
46	WHOLE BLOOD & PACKED RED	98,088	1,713	96,375			98,088
46 30	BLOOD CLOTTING FACTORS AD						
49	RESPIRATORY THERAPY	1,065,608	41,387	1,024,221			1,065,608
50	PHYSICAL THERAPY	1,030,463	55,892	974,571			1,030,463
51	OCCUPATIONAL THERAPY	308,283	25,722	282,561			308,283
52	SPEECH PATHOLOGY	537,528	27,991	509,537			537,528
53	ELECTROCARDIOLOGY	285,218	17,395	267,823			285,218
55	MEDICAL SUPPLIES CHARGED	2,853,294	74,253	2,779,041			2,853,294
55 30	IMPL. DEV. CHARGED TO PAT	22,226	313	21,913			22,226
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	3,702,642	90,884	3,611,758			3,702,642
60	CLINIC	570,850	35,071	535,779			570,850
60 01	ONCOLOGY	518,946	20,245	498,701			518,946
60 02	OUTPATIENT CLINIC	414,795	93,851	320,944			414,795
60 03	PROVIDER BASED CLINIC - T	1,135,943	243,199	892,744			1,135,943
60 04	PROVIDER BASED CLINIC - D	1,382,010	106,153	1,275,857			1,382,010
60 05	PROVIDER BASED CLINIC - W	186,460	18,963	167,497			186,460
60 06	CLINIC	289,415	37,434	251,981			289,415
61	EMERGENCY	2,699,892	127,615	2,572,277			2,699,892
62	OBSERVATION BEDS (NON-DIS	1,340,186		1,340,186			1,340,186
63 50	RHC						
63 60	FQHC						
65	OTHER REIMBURS COST CNTRS						
	AMBULANCE SERVICES	1,169,453	67,405	1,102,048			1,169,453
101	SUBTOTAL	28,027,273	1,721,573	26,305,700			28,027,273
102	LESS OBSERVATION BEDS	1,340,186		1,340,186			1,340,186
103	TOTAL	26,687,087	1,721,573	24,965,514			26,687,087

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGR RATIO	I/P PT B COST TO CHRGR RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	6,970,106	.317061	.317061
39	DELIVERY ROOM & LABOR ROO	379,589	1.004897	1.004897
40	ANESTHESIOLOGY	429,996	.601608	.601608
41	RADIOLOGY-DIAGNOSTIC	15,591,046	.198531	.198531
41 01	ULTRA SOUND	1,687,034	.118727	.118727
44	LABORATORY	11,438,885	.198471	.198471
46	WHOLE BLOOD & PACKED RED	428,428	.228949	.228949
46 30	BLOOD CLOTTING FACTORS AD			
49	RESPIRATORY THERAPY	1,769,752	.602123	.602123
50	PHYSICAL THERAPY	1,923,522	.535717	.535717
51	OCCUPATIONAL THERAPY	493,513	.624670	.624670
52	SPEECH PATHOLOGY	655,912	.819512	.819512
53	ELECTROCARDIOLOGY	2,425,559	.117589	.117589
55	MEDICAL SUPPLIES CHARGED	3,882,913	.734833	.734833
55 30	IMPL. DEV. CHARGED TO PAT	24,908	.892324	.892324
56	DRUGS CHARGED TO PATIENTS	8,045,137	.460234	.460234
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	245,325	2.326913	2.326913
60 01	ONCOLOGY	240,751	2.155530	2.155530
60 02	OUTPATIENT CLINIC	227,952	1.819659	1.819659
60 03	PROVIDER BASED CLINIC - T	899,570	1.262762	1.262762
60 04	PROVIDER BASED CLINIC - D	529,270	2.611163	2.611163
60 05	PROVIDER BASED CLINIC - W	89,142	2.091719	2.091719
60 06	CLINIC	129,995	2.226355	2.226355
61	EMERGENCY	5,299,972	.509416	.509416
62	OBSERVATION BEDS (NON-DIS	1,085,750	1.234341	1.234341
63 50	RHC			
63 60	FQHC			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	2,197,981	.532058	.532058
101	SUBTOTAL	67,092,008		
102	LESS OBSERVATION BEDS	1,085,750		
103	TOTAL	66,006,258		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
37	ANCILLARY SRVC COST CNTRS					
	OPERATING ROOM	2,209,946	6,970,106			
39	DELIVERY ROOM & LABOR ROO	381,448	379,589			
40	ANESTHESIOLOGY	258,689	429,996			
41	RADIOLOGY-DIAGNOSTIC	3,095,309	15,591,046			
41 01	ULTRA SOUND	200,297	1,687,034			
44	LABORATORY	2,270,284	11,438,885			
46	WHOLE BLOOD & PACKED RED	98,088	428,428			
46 30	BLOOD CLOTTING FACTORS AD					
49	RESPIRATORY THERAPY	1,065,608	1,769,752			
50	PHYSICAL THERAPY	1,030,463	1,923,522			
51	OCCUPATIONAL THERAPY	308,283	493,513			
52	SPEECH PATHOLOGY	537,528	655,912			
53	ELECTROCARDIOLOGY	285,218	2,425,559			
55	MEDICAL SUPPLIES CHARGED	2,853,294	3,882,913			
55 30	IMPL. DEV. CHARGED TO PAT	22,226	24,908			
56	DRUGS CHARGED TO PATIENTS	3,702,642	8,045,137			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	570,850	245,325			
60 01	ONCOLOGY	518,946	240,751			
60 02	OUTPATIENT CLINIC	414,795	227,952			
60 03	PROVIDER BASED CLINIC - T	1,135,943	899,570			
60 04	PROVIDER BASED CLINIC - D	1,382,010	529,270			
60 05	PROVIDER BASED CLINIC - W	186,460	89,142			
60 06	CLINIC	289,415	129,995			
61	EMERGENCY	2,699,892	5,299,972			
62	OBSERVATION BEDS (NON-DIS	1,340,186	1,085,750			
63 50	RHC					
63 60	FQHC					
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	1,169,453	2,197,981			
101	TOTAL	28,027,273	67,092,008			

COMPUTATION OF OUTPATIENT COST PER VISIT -
RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
I 15-1332 I FROM 1/ 1/2010 I WORKSHEET C
I I TO 12/31/2010 I PART V

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT- PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT- PATIENT COSTS 7
37	ANCILLARY SRVC COST CNTRS							
	OPERATING ROOM	2,209,946		2,209,946	6,970,106			
39	DELIVERY ROOM & LABOR ROO	381,448		381,448	379,589			
40	ANESTHESIOLOGY	258,689	630,743	889,432	429,996			
41	RADIOLOGY-DIAGNOSTIC	3,095,309		3,095,309	15,591,046			
41 01	ULTRA SOUND	200,297		200,297	1,687,034			
44	LABORATORY	2,270,284		2,270,284	11,438,885			
46	WHOLE BLOOD & PACKED RED	98,088		98,088	428,428			
46 30	BLOOD CLOTTING FACTORS AD							
49	RESPIRATORY THERAPY	1,065,608		1,065,608	1,769,752			
50	PHYSICAL THERAPY	1,030,463		1,030,463	1,923,522			
51	OCCUPATIONAL THERAPY	308,283		308,283	493,513			
52	SPEECH PATHOLOGY	537,528		537,528	655,912			
53	ELECTROCARDIOLOGY	285,218	152,325	437,543	2,425,559			
55	MEDICAL SUPPLIES CHARGED	2,853,294		2,853,294	3,882,913			
55 30	IMPL. DEV. CHARGED TO PAT	22,226		22,226	24,908			
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	3,702,642		3,702,642	8,045,137			
60	CLINIC	570,850	310,353	881,203	245,325			
60 01	ONCOLOGY	518,946		518,946	240,751			
60 02	OUTPATIENT CLINIC	414,795	166,287	581,082	227,952			
60 03	PROVIDER BASED CLINIC - T	1,135,943	1,254,520	2,390,463	899,570			
60 04	PROVIDER BASED CLINIC - D	1,382,010		1,382,010	529,270			
60 05	PROVIDER BASED CLINIC - W	186,460		186,460	89,142			
60 06	CLINIC	289,415	75,363	364,778	129,995			
61	EMERGENCY	2,699,892	922,985	3,622,877	5,299,972			
62	OBSERVATION BEDS (NON-DIS	1,340,186		1,340,186	1,085,750			
63 50	RHC							
63 60	FQHC							
65	OTHER REIMBURS COST CNTRS							
	AMBULANCE SERVICES	1,169,453		1,169,453	2,197,981			
101	TOTAL	28,027,273	3,512,576	31,539,849	67,092,008			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

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	.317061		.317061		
39 DELIVERY ROOM & LABOR ROOM	1.004897		1.004897		
40 ANESTHESIOLOGY	.601608		.601608		
41 RADIOLOGY-DIAGNOSTIC	.198531		.198531		
41 01 ULTRA SOUND	.118727		.118727		
44 LABORATORY	.198471		.198471		
46 WHOLE BLOOD & PACKED RED BLOOD CELLS	.228949		.228949		
46 30 BLOOD CLOTTING FACTORS ADMIN COSTS					
49 RESPIRATORY THERAPY	.602123		.602123		
50 PHYSICAL THERAPY	.535717		.535717		
51 OCCUPATIONAL THERAPY	.624670		.624670		
52 SPEECH PATHOLOGY	.819512		.819512		
53 ELECTROCARDIOLOGY	.117589		.117589		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.734833		.734833		
55 30 IMPL. DEV. CHARGED TO PATIENT	.892324		.892324		
56 DRUGS CHARGED TO PATIENTS	.460234		.460234		
OUTPAT SERVICE COST CNTRS					
60 CLINIC	2.326913		2.326913		
60 01 ONCOLOGY	2.155530		2.155530		
60 02 OUTPATIENT CLINIC	1.819659		1.819659		
60 03 PROVIDER BASED CLINIC - TCMP	1.262762		1.262762		
60 04 PROVIDER BASED CLINIC - DCPC	2.611163		2.611163		
60 05 PROVIDER BASED CLINIC - WESTPORT	2.091719		2.091719		
60 06 CLINIC	2.226355		2.226355		
61 EMERGENCY	.509416		.509416		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.234341		1.234341		
63 50 RHC					
63 60 FQHC					
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES	.532058		.532058		
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART V
 I 15-1332 I I

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		1,018,489			
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY		46,476			
41 RADIOLOGY-DIAGNOSTIC		4,290,202			
41 01 ULTRA SOUND		362,386			
44 LABORATORY		3,110,676			
46 WHOLE BLOOD & PACKED RED BLOOD CELLS		115,998			
46 30 BLOOD CLOTTING FACTORS ADMIN COSTS					
49 RESPIRATORY THERAPY		322,039			
50 PHYSICAL THERAPY		324,110			
51 OCCUPATIONAL THERAPY		48,382			
52 SPEECH PATHOLOGY		29,742			
53 ELECTROCARDIOLOGY		736,115			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		355,240			
55 30 IMPL. DEV. CHARGED TO PATIENT		14,373			
56 DRUGS CHARGED TO PATIENTS		1,999,941			
OUTPAT SERVICE COST CNTRS					
60 CLINIC		9,587			
60 01 ONCOLOGY		110,233			
60 02 OUTPATIENT CLINIC		24,878			
60 03 PROVIDER BASED CLINIC - TCMP		190,761			
60 04 PROVIDER BASED CLINIC - DCPC		79,123			
60 05 PROVIDER BASED CLINIC - WESTPORT		21,377			
60 06 CLINIC		39,777			
61 EMERGENCY		1,181,531			
62 OBSERVATION BEDS (NON-DISTINCT PART)		505,507			
63 50 RHC					
63 60 FQHC					
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES					
101 SUBTOTAL		14,936,943			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		14,936,943			

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART V
 I 15-1332 I I

TITLE XVIII, PART B

HOSPITAL

All other Hospital I/P Hospital I/P
 Part B Charges Part B Costs

Cost Center Description	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM	322,923		
39 DELIVERY ROOM & LABOR ROOM			
40 ANESTHESIOLOGY	27,960		
41 RADIOLOGY-DIAGNOSTIC	851,738		
41 01 ULTRA SOUND	43,025		
44 LABORATORY	617,379		
46 WHOLE BLOOD & PACKED RED BLOOD CELLS	26,558		
46 30 BLOOD CLOTTING FACTORS ADMIN COSTS			
49 RESPIRATORY THERAPY	193,907		
50 PHYSICAL THERAPY	173,631		
51 OCCUPATIONAL THERAPY	30,223		
52 SPEECH PATHOLOGY	24,374		
53 ELECTROCARDIOLOGY	86,559		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	261,042		
55 30 IMPL. DEV. CHARGED TO PATIENT	12,825		
56 DRUGS CHARGED TO PATIENTS	920,441		
OUTPAT SERVICE COST CNTRS			
60 CLINIC	22,308		
60 01 ONCOLOGY	237,611		
60 02 OUTPATIENT CLINIC	45,269		
60 03 PROVIDER BASED CLINIC - TCMP	240,886		
60 04 PROVIDER BASED CLINIC - DCPC	206,603		
60 05 PROVIDER BASED CLINIC - WESTPORT	44,715		
60 06 CLINIC	88,558		
61 EMERGENCY	601,891		
62 OBSERVATION BEDS (NON-DISTINCT PART)	623,968		
63 50 RHC			
63 60 FQHC			
OTHER REIMBURS COST CNTRS			
65 AMBULANCE SERVICES			
101 SUBTOTAL	5,704,394		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104 NET CHARGES	5,704,394		

(A) WORKSHEET A LINE NUMBERS

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

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/31/2011
I	15-1332	I	FROM 1/ 1/2010	I	WORKSHEET D	
I	COMPONENT NO:	I	TO 12/31/2010	I	PART VI	
I	15-1332	I		I		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES
2	PROGRAM VACCINE CHARGES
3	PROGRAM COSTS

1
.460234
4,853
2,234

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

TITLE XIX

WKST A LINE 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
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS				319,749	22,718	297,031
26	INTENSIVE CARE UNIT				29,105		29,105
33	NURSERY				17,029		17,029
101	TOTAL				365,883		343,165

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET D
 I I TO 12/31/2010 I PART I

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

TITLE XIX

PPS

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	4,669	165			63.62	10,497
26	INTENSIVE CARE UNIT	124				234.72	
33	NURSERY	631				26.99	
101	TOTAL	5,424	165				10,497

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART II
 I 15-1332 I

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

TITLE XIX		HOSPITAL		PPS			
WKST A	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST	NEW CAPITAL RELATED COST	TOTAL CHARGES	INPAT PROGRAM CHARGES	OLD CAPITAL CST/CHRG RATIO	CAPITAL COSTS
LINE NO.		1	2	3	4	5	6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM		189,711	6,970,106	77,694		
39	DELIVERY ROOM & LABOR ROO		141,106	379,589	49,079		
40	ANESTHESIOLOGY		3,903	429,996	36,481		
41	RADIOLOGY-DIAGNOSTIC		189,304	15,591,046	23,699		
41 01	ULTRA SOUND		4,349	1,687,034	5,644		
44	LABORATORY		107,714	11,438,885	55,201		
46	WHOLE BLOOD & PACKED RED		1,713	428,428	6,825		
46 30	BLOOD CLOTTING FACTORS AD						
49	RESPIRATORY THERAPY		41,387	1,769,752	22,410		
50	PHYSICAL THERAPY		55,892	1,923,522	989		
51	OCCUPATIONAL THERAPY		25,722	493,513	1,268		
52	SPEECH PATHOLOGY		27,991	655,912	4,806		
53	ELECTROCARDIOLOGY		17,395	2,425,559	2,605		
55	MEDICAL SUPPLIES CHARGED		74,253	3,882,913	63,316		
55 30	IMPL. DEV. CHARGED TO PAT		313	24,908			
56	DRUGS CHARGED TO PATIENTS		90,884	8,045,137	90,962		
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		35,071	245,325			
60 01	ONCOLOGY		20,245	240,751			
60 02	OUTPATIENT CLINIC		93,851	227,952			
60 03	PROVIDER BASED CLINIC - T		243,199	899,570			
60 04	PROVIDER BASED CLINIC - D		106,153	529,270			
60 05	PROVIDER BASED CLINIC - W		18,963	89,142			
60 06	CLINIC		37,434	129,995			
61	EMERGENCY		127,615	5,299,972	3,906		
62	OBSERVATION BEDS (NON-DIS			1,085,750			
63 50	RHC						
63 60	FQHC						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
101	TOTAL		1,654,168	64,894,027	444,885		

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART II
 I 15-1332 I

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

TITLE XIX		HOSPITAL	
WKST A	COST CENTER DESCRIPTION	NEW CAPITAL	
LINE NO.		CST/CHRG RATIO	COSTS
		7	8
37	ANCILLARY SRVC COST CNTRS		
	OPERATING ROOM	.027218	2,115
39	DELIVERY ROOM & LABOR ROO	.371734	18,244
40	ANESTHESIOLOGY	.009077	331
41	RADIOLOGY-DIAGNOSTIC	.012142	288
41 01	ULTRA SOUND	.002578	15
44	LABORATORY	.009416	520
46	WHOLE BLOOD & PACKED RED	.003998	27
46 30	BLOOD CLOTTING FACTORS AD		
49	RESPIRATORY THERAPY	.023386	524
50	PHYSICAL THERAPY	.029057	29
51	OCCUPATIONAL THERAPY	.052120	66
52	SPEECH PATHOLOGY	.042675	205
53	ELECTROCARDIOLOGY	.007172	19
55	MEDICAL SUPPLIES CHARGED	.019123	1,211
55 30	IMPL. DEV. CHARGED TO PAT	.012566	
56	DRUGS CHARGED TO PATIENTS	.011297	1,028
	OUTPAT SERVICE COST CNTRS		
60	CLINIC	.142957	
60 01	ONCOLOGY	.084091	
60 02	OUTPATIENT CLINIC	.411714	
60 03	PROVIDER BASED CLINIC - T	.270350	
60 04	PROVIDER BASED CLINIC - D	.200565	
60 05	PROVIDER BASED CLINIC - W	.212728	
60 06	CLINIC	.287965	
61	EMERGENCY	.024078	94
62	OBSERVATION BEDS (NON-DIS		
63 50	RHC		
63 60	FQHC		
	OTHER REIMBURS COST CNTRS		
65	AMBULANCE SERVICES		
101	TOTAL		24,716

PPS

Health Financial Systems MCRIF32

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IN LIEU OF FORM CMS-2552-96(11/1998)

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
I 15-1332 I FROM 1/ 1/2010 I WORKSHEET D
I I TO 12/31/2010 I PART III
PPS

APPORTIONMENT OF INPATIENT ROUTINE
SERVICE OTHER PASS THROUGH COSTS
TITLE XIX

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	MED EDUCATN COST 2	SWING BED ADJ AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS					4,669	
26	INTENSIVE CARE UNIT					124	
33	NURSERY					631	
101	TOTAL					5,424	

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET D
 I I TO 12/31/2010 I PART III

APPORTIONMENT OF INPATIENT ROUTINE
 SERVICE OTHER PASS THROUGH COSTS
 TITLE XIX

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT PROG DAYS	INPAT PROGRAM PASS THRU COST
25	ADULTS & PEDIATRICS	7	165
26	INTENSIVE CARE UNIT		8
33	NURSERY		
101	TOTAL		165

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TITLE XIX

HOSPITAL

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST	HOSPITAL	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
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
41 01	ULTRA SOUND						
44	LABORATORY						
46	WHOLE BLOOD & PACKED RED						
46 30	BLOOD CLOTTING FACTORS AD						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY						
55	MEDICAL SUPPLIES CHARGED						
55 30	IMPL. DEV. CHARGED TO PAT						
56	DRUGS CHARGED TO PATIENTS						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
60 01	ONCOLOGY						
60 02	OUTPATIENT CLINIC						
60 03	PROVIDER BASED CLINIC - T						
60 04	PROVIDER BASED CLINIC - D						
60 05	PROVIDER BASED CLINIC - W						
60 06	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
63 50	RHC						
63 60	FQHC						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
101	TOTAL						

TITLE XIX

HOSPITAL

PPS

WKST A LINE 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
37	ANCILLARY SRVC COST CNTRS							
	OPERATING ROOM			6,970,106			77,694	
39	DELIVERY ROOM & LABOR ROO			379,589			49,079	
40	ANESTHESIOLOGY			429,996			36,481	
41	RADIOLOGY-DIAGNOSTIC			15,591,046			23,699	
41 01	ULTRA SOUND			1,687,034			5,644	
44	LABORATORY			11,438,885			55,201	
46	WHOLE BLOOD & PACKED RED			428,428			6,825	
46 30	BLOOD CLOTTING FACTORS AD							
49	RESPIRATORY THERAPY			1,769,752			22,410	
50	PHYSICAL THERAPY			1,923,522			989	
51	OCCUPATIONAL THERAPY			493,513			1,268	
52	SPEECH PATHOLOGY			655,912			4,806	
53	ELECTROCARDIOLOGY			2,425,559			2,605	
55	MEDICAL SUPPLIES CHARGED			3,882,913			63,316	
55 30	IMPL. DEV. CHARGED TO PAT			24,908				
56	DRUGS CHARGED TO PATIENTS			8,045,137			90,962	
	OUTPAT SERVICE COST CNTRS							
60	CLINIC			245,325				
60 01	ONCOLOGY			240,751				
60 02	OUTPATIENT CLINIC			227,952				
60 03	PROVIDER BASED CLINIC - T			899,570				
60 04	PROVIDER BASED CLINIC - D			529,270				
60 05	PROVIDER BASED CLINIC - W			89,142				
60 06	CLINIC			129,995				
61	EMERGENCY			5,299,972			3,906	
62	OBSERVATION BEDS (NON-DIS			1,085,750				
63 50	RHC							
63 60	FQHC							
	OTHER REIMBURS COST CNTRS							
65	AMBULANCE SERVICES							
101	TOTAL			64,894,027			444,885	

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
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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
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
41 01	ULTRA SOUND						
44	LABORATORY						
46	WHOLE BLOOD & PACKED RED						
46 30	BLOOD CLOTTING FACTORS AD						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY						
55	MEDICAL SUPPLIES CHARGED						
55 30	IMPL. DEV. CHARGED TO PAT						
56	DRUGS CHARGED TO PATIENTS						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
60 01	ONCOLOGY						
60 02	OUTPATIENT CLINIC						
60 03	PROVIDER BASED CLINIC - T						
60 04	PROVIDER BASED CLINIC - D						
60 05	PROVIDER BASED CLINIC - W						
60 06	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
63 50	RHC						
63 60	FQHC						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
101	TOTAL						

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2010 I PART I
 I 15-1332 I I

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	5,063
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,669
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,669
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	351
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	43
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)	1,580
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	351
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	143.79
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	5,091,418
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	6,183
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	361,746
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,729,672

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,835,142
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,835,142
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.668231
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	607.23
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	4,729,672

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM					1,013.00
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					1,600,540
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					1,600,540

	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	643,796	124	5,191.90	72	373,817
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				
49	TOTAL PROGRAM INPATIENT COSTS				

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
58	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)	355,563
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	355,563
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	

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COMPUTATION OF INPATIENT OPERATING COST

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	1,323
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,012.99
85	OBSERVATION BED COST	1,340,186

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				
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
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TITLE XIX - I/P

HOSPITAL

PPS

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	5,063
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,669
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,669
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	351
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	43
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)	165
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)	631
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	143.79
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	143.79
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	5,091,418
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	50,470
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	6,183
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	361,746
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,729,672

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,835,142
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,835,142
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.668231
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	607.23
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	4,729,672

TITLE XIX - I/P HOSPITAL PPS

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	1,013.00
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	167,145
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	167,145

	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) INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS	339,822	631	538.55	
43	INTENSIVE CARE UNIT	643,796	124	5,191.90	
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				1 223,236
49	TOTAL PROGRAM INPATIENT COSTS				390,381

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	10,497
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	24,716
52	TOTAL PROGRAM EXCLUDABLE COST	35,213
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	355,168

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
58	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

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2010 I PART III
 I 15-1332 I I

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 1,323
 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 1,012.99
 85 OBSERVATION BED COST 1,340,186

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		4,729,672		1,340,186	
87 NEW CAPITAL-RELATED COST	319,749	4,729,672	.067605	1,340,186	90,603
88 NON PHYSICIAN ANESTHETIST		4,729,672		1,340,186	
89 MEDICAL EDUCATION		4,729,672		1,340,186	
89.01 MEDICAL EDUCATION - ALLIED HEA					
89.02 MEDICAL EDUCATION - ALL OTHER					

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-1332 I

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		1,322,532	
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS		131,137	
37	OPERATING ROOM	.317061	445,955	141,395
39	DELIVERY ROOM & LABOR ROOM	1.004897		
40	ANESTHESIOLOGY	.601608	37,145	22,347
41	RADIOLOGY-DIAGNOSTIC	.198531	442,144	87,779
41 01	ULTRA SOUND	.118727	47,590	5,650
44	LABORATORY	.198471	605,849	120,243
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	.228949	100,726	23,061
46 30	BLOOD CLOTTING FACTORS ADMIN COSTS			
49	RESPIRATORY THERAPY	.602123	623,700	375,544
50	PHYSICAL THERAPY	.535717	97,116	52,027
51	OCCUPATIONAL THERAPY	.624670	68,244	42,630
52	SPEECH PATHOLOGY	.819512	12,085	9,904
53	ELECTROCARDIOLOGY	.117589	128,465	15,106
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.734833	748,843	550,275
55 30	IMPL. DEV. CHARGED TO PATIENT	.892324		
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	.460234	1,116,364	513,789
60	CLINIC	2.326913		
60 01	ONCOLOGY	2.155530		
60 02	OUTPATIENT CLINIC	1.819659	4,436	8,072
60 03	PROVIDER BASED CLINIC - TCMP	1.262762		
60 04	PROVIDER BASED CLINIC - DCPC	2.611163		
60 05	PROVIDER BASED CLINIC - WESTPORT	2.091719		
60 06	CLINIC	2.226355		
61	EMERGENCY	.509416	2,209	1,125
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.234341		
63 50	RHC			
63 60	FQHC			
65	OTHER REIMBURS COST CNTRS AMBULANCE SERVICES			
101	TOTAL		4,480,871	1,968,947
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		4,480,871	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-Z332 I I

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			
26	INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.317061		
39	DELIVERY ROOM & LABOR ROOM	1.004897		
40	ANESTHESIOLOGY	.601608		
41	RADIOLOGY-DIAGNOSTIC	.198531	19,257	3,823
41 01	ULTRA SOUND	.118727	2,481	295
44	LABORATORY	.198471	51,016	10,125
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	.228949	6,137	1,405
46 30	BLOOD CLOTTING FACTORS ADMIN COSTS			
49	RESPIRATORY THERAPY	.602123	35,774	21,540
50	PHYSICAL THERAPY	.535717	66,491	35,620
51	OCCUPATIONAL THERAPY	.624670	49,805	31,112
52	SPEECH PATHOLOGY	.819512	3,319	2,720
53	ELECTROCARDIOLOGY	.117589	1,400	165
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.734833	31,641	23,251
55 30	IMPL. DEV. CHARGED TO PATIENT	.892324		
56	DRUGS CHARGED TO PATIENTS	.460234	120,075	55,263
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	2.326913		
60 01	ONCOLOGY	2.155530		
60 02	OUTPATIENT CLINIC	1.819659	285	519
60 03	PROVIDER BASED CLINIC - TCMP	1.262762		
60 04	PROVIDER BASED CLINIC - DCPC	2.611163		
60 05	PROVIDER BASED CLINIC - WESTPORT	2.091719		
60 06	CLINIC	2.226355		
61	EMERGENCY	.509416		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.234341		
63 50	RHC			
63 60	FQHC			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		387,681	185,838
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		387,681	

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-1332 I

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

TITLE XIX HOSPITAL PPS

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		203,901	
26	INTENSIVE CARE UNIT		6,072	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.317061	77,694	24,634
39	DELIVERY ROOM & LABOR ROOM	1.004897	49,079	49,319
40	ANESTHESIOLOGY	.601608	36,481	21,947
41	RADIOLOGY-DIAGNOSTIC	.198531	23,699	4,705
41 01	ULTRA SOUND	.118727	5,644	670
44	LABORATORY	.198471	55,201	10,956
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	.228949	6,825	1,563
46 30	BLOOD CLOTTING FACTORS ADMIN COSTS			
49	RESPIRATORY THERAPY	.602123	22,410	13,494
50	PHYSICAL THERAPY	.535717	989	530
51	OCCUPATIONAL THERAPY	.624670	1,268	792
52	SPEECH PATHOLOGY	.819512	4,806	3,939
53	ELECTROCARDIOLOGY	.117589	2,605	306
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.734833	63,316	46,527
55 30	IMPL. DEV. CHARGED TO PATIENT	.892324		
56	DRUGS CHARGED TO PATIENTS	.460234	90,962	41,864
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	2.326913		
60 01	ONCOLOGY	2.155530		
60 02	OUTPATIENT CLINIC	1.819659		
60 03	PROVIDER BASED CLINIC - TCMP	1.262762		
60 04	PROVIDER BASED CLINIC - DCPC	2.611163		
60 05	PROVIDER BASED CLINIC - WESTPORT	2.091719		
60 06	CLINIC	2.226355		
61	EMERGENCY	.509416	3,906	1,990
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.234341		
63 50	RHC			
63 60	FQHC			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		444,885	223,236
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		444,885	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET E
 I COMPONENT NO: I TO 12/31/2010 I PART B
 I 15-1332 I I

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) 5,706,628
 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) 5,706,628

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) 5,763,694
 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18 CAH DEDUCTIBLES 86,581
 18.01 CAH ACTUAL BILLED COINSURANCE 2,336,324
 LINE 17.01 (SEE INSTRUCTIONS)
 19 SUBTOTAL (SEE INSTRUCTIONS) 3,340,789
 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 3,340,789
 24 PRIMARY PAYER PAYMENTS 1,168
 25 SUBTOTAL 3,339,621

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26 COMPOSITE RATE ESRD
 27 BAD DEBTS (SEE INSTRUCTIONS) 680,605
 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) 680,605
 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES 602,448
 28 SUBTOTAL 4,020,226
 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 4,020,226
 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)
 34 INTERIM PAYMENTS 3,591,800
 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)
 35 BALANCE DUE PROVIDER/PROGRAM 428,426
 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)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-1332 I

TITLE XVIII HOSPITAL

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		3,342,200		3,300,708
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	9/ 7/2010	79,011		
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03	9/ 7/2010	62,391	9/ 7/2010	347,488
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROVIDER .49				
ADJUSTMENTS TO PROGRAM .50			7/15/2010	56,396
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		141,402		291,092
4 TOTAL INTERIM PAYMENTS		3,483,602		3,591,800
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 .99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		240,299		428,426
7 TOTAL MEDICARE PROGRAM LIABILITY		3,723,901		4,020,226

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.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-2332 I I

TITLE XVIII SWING BED SNF

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		477,388		
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	9/ 7/2010	34,221		
ADJUSTMENTS TO PROVIDER .02				
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 .99		34,221		NONE
4 TOTAL INTERIM PAYMENTS		511,609		
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 .99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01	30,806		
	SETTLEMENT TO PROGRAM .02			
7 TOTAL MEDICARE PROGRAM LIABILITY		542,415		

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)	359,119	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	187,696	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	351	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	546,815	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	546,815	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	546,815	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	4,400	
14	80% OF PART B COSTS		
15	SUBTOTAL	542,415	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	542,415	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	511,609	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	30,806	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET E-3
 I COMPONENT NO: I TO 12/31/2010 I PART II
 I 15-1332 I I

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	3,943,304
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	3,943,304
5	PRIMARY PAYER PAYMENTS	5,088
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	3,977,598

COMPUTATION OF LESSER OF COST OR CHARGES

7	REASONABLE CHARGES	
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
12	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	3,977,598
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	390,435
21	EXCESS REASONABLE COST	
22	SUBTOTAL	3,587,163
23	COINSURANCE	5,775
24	SUBTOTAL	3,581,388
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	142,513
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	142,513
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	78,773
26	SUBTOTAL	3,723,901
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	3,723,901
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	3,483,602
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	240,299
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	2,225,237			
2	TEMPORARY INVESTMENTS	11,412,871			
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	6,058,561			
5	OTHER RECEIVABLES	309,439			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7	INVENTORY	351,146			
8	PREPAID EXPENSES	469,725			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	20,826,979			
FIXED ASSETS					
12	LAND				
12.01	LAND IMPROVEMENTS	24,863,615			
13.01	LESS ACCUMULATED DEPRECIATION BUILDINGS				
14.01	LESS ACCUMULATED DEPRECIATION LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION MINOR EQUIPMENT-NONDEPRECIABLE				
20	TOTAL FIXED ASSETS	24,863,615			
OTHER ASSETS					
22	INVESTMENTS	5,084,496			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS				
26	TOTAL OTHER ASSETS	5,084,496			
27	TOTAL ASSETS	50,775,090			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	1,866,361			
29 SALARIES, WAGES & FEES PAYABLE				
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	2,746,226			
36 TOTAL CURRENT LIABILITIES	4,612,587			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE				
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES	3,483,671			
42 TOTAL LONG-TERM LIABILITIES	3,483,671			
43 TOTAL LIABILITIES	8,096,258			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	42,678,832			
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	42,678,832			
52 TOTAL LIABILITIES AND FUND BALANCES	50,775,090			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING		41,879,576		
2 OF PERIOD				
3 NET INCOME (LOSS)		973,109		
4 TOTAL		42,852,685		
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
6 ADDITIONS (CREDIT ADJUSTM				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL		42,852,685		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM		173,853		
14				
15				
16				
17				
18 TOTAL DEDUCTIONS		173,853		
19 FUND BALANCE AT END OF		42,678,832		
PERIOD PER BALANCE SHEET				

	ENDOWMENT FUND		PLANT FUND	
	5	6	7	8
1 FUND BALANCE AT BEGINNING				
2 OF PERIOD				
3 NET INCOME (LOSS)				
4 TOTAL				
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
6 ADDITIONS (CREDIT ADJUSTM				
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				

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET G-2
 I I TO 12/31/2010 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	3,337,419		3,337,419
4 00 SWING BED - SNF	619,621		619,621
5 00 SWING BED - NF			
8 00 OTHER LONG TERM CARE	63,124		63,124
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	4,020,164		4,020,164
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT	229,028		229,028
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	229,028		229,028
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	4,249,192		4,249,192
17 00 ANCILLARY SERVICES	11,421,516	45,357,889	56,779,405
18 00 OUTPATIENT SERVICES	1,079,488	14,797,404	15,876,892
18 50 RHC			
18 60 FQHC			
19 00 HOME HEALTH AGENCY		1,796,526	1,796,526
20 00 AMBULANCE SERVICES		2,197,981	2,197,981
21 10 CMHC			
21 20 OUTPATIENT PHYSICAL THERAPY			
21 30 OUTPATIENT OCCUPATIONAL THERAPY			
21 40 OUTPATIENT SPEECH PATHOLOGY			
24 00			
25 00 TOTAL PATIENT REVENUES	16,750,196	64,149,800	80,899,996

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES	40,397,103		
ADD (SPECIFY)			
27 00 ADD (SPECIFY)			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		40,397,103	

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET G-3
 I I TO 12/31/2010 I

DESCRIPTION

1	TOTAL PATIENT REVENUES	80,899,996
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	41,008,528
3	NET PATIENT REVENUES	39,891,468
4	LESS: TOTAL OPERATING EXPENSES	40,397,103
5	NET INCOME FROM SERVICE TO PATIENTS	-505,635
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
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	
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER OPERATING	887,935
24.01	OTHER NON OPERATING	590,809
25	TOTAL OTHER INCOME	1,478,744
26	TOTAL	973,109
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	973,109

HHA 1

	SALARIES	EMPLOYEE BENEFITS	TRANSPORTATION	CONTRACTED/ PURCHASED SVCS	OTHER COSTS	TOTAL
	1	2	3	4	5	6

GENERAL SERVICE COST CENTERS						
1	CAP-REL COST-BLDG & FIX					
2	CAP-REL COST-MOV EQUIP					
3	PLANT OPER & MAINT					
4	TRANSPORTATION					
5	ADMIN & GENERAL	178,967	218		21,238	200,423
HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	515,234	33,778			549,012
7	PHYSICAL THERAPY	147,854	12,337	30,243		190,434
8	OCCUPATIONAL THERAPY	72,252	4,821			77,073
9	SPEECH PATHOLOGY	1,700	31			1,731
10	MEDICAL SOCIAL SERVICES	3,834	279			4,113
11	HOME HEALTH AIDE	99,940	24,755			124,695
12	SUPPLIES					
13	DRUGS					
13.20	COST ADMINISTERING DRUGS					
14	DME					
HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SVCS					
16	RESPIRATORY THERAPY					
17	PRIVATE DUTY NURSING					
18	CLINIC					
19	HEALTH PROM ACTIVITIES					
20	DAY CARE PROGRAM					
21	HOME DEL MEALS PROGRAM					
22	HOMEMAKER SERVICE					
23	ALL OTHER					
23.50	TELEMEDICINE					
24	TOTAL (SUM OF LINES 1-23)	1,019,781	76,219	30,243	21,238	1,147,481

	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION
	7	8	9	10

GENERAL SERVICE COST CENTERS				
1	CAP-REL COST-BLDG & FIX			
2	CAP-REL COST-MOV EQUIP			
3	PLANT OPER & MAINT			
4	TRANSPORTATION			
5	ADMIN & GENERAL	200,423		200,423
HHA REIMBURSABLE SERVICES				
6	SKILLED NURSING CARE	549,012		549,012
7	PHYSICAL THERAPY	190,434		190,434
8	OCCUPATIONAL THERAPY	77,073		77,073
9	SPEECH PATHOLOGY	1,731		1,731
10	MEDICAL SOCIAL SERVICES	4,113		4,113
11	HOME HEALTH AIDE	124,695		124,695
12	SUPPLIES			
13	DRUGS			
13.20	COST ADMINISTERING DRUGS			
14	DME			
HHA NONREIMBURSABLE SERVICES				
15	HOME DIALYSIS AIDE SVCS			
16	RESPIRATORY THERAPY			
17	PRIVATE DUTY NURSING			
18	CLINIC			
19	HEALTH PROM ACTIVITIES			
20	DAY CARE PROGRAM			
21	HOME DEL MEALS PROGRAM			
22	HOMEMAKER SERVICE			
23	ALL OTHER			
23.50	TELEMEDICINE			
24	TOTAL (SUM OF LINES 1-23)	1,147,481		1,147,481

HHA 1

	NET EXPENSES FOR COST ALLOCATION	CAP-REL COST-BLDG & FIX	CAP-REL COST-MOV EQUIP	PLANT OPER & MAINT	TRANSPORTATIO N	SUBTOTAL	ADMINISTRATIV E & GENERAL
	0	1	2	3	4	4A	5
GENERAL SERVICE COST CENTERS							
1							
2							
3							
4							
5	200,423					200,423	200,423
HHA REIMBURSABLE SERVICES							
6	549,012					549,012	116,186
7	190,434					190,434	40,301
8	77,073					77,073	16,311
9	1,731					1,731	366
10	4,113					4,113	870
11	124,695					124,695	26,389
12							
13							
13.20							
14							
HHA NONREIMBURSABLE SERVICES							
15							
16							
17							
18							
19							
20							
21							
22							
23							
23.50							
24	1,147,481					1,147,481	

TOTAL

6

GENERAL SERVICE COST CENTERS							
1							
2							
3							
4							
5							
HHA REIMBURSABLE SERVICES							
6	665,198						
7	230,735						
8	93,384						
9	2,097						
10	4,983						
11	151,084						
12							
13							
13.20							
14							
HHA NONREIMBURSABLE SERVICES							
15							
16							
17							
18							
19							
20							
21							
22							
23							
23.50							
24	1,147,481						

HHA 1

HHA COST CENTER	HHA TRIAL BALANCE (1) 0	NEW CAP REL COSTS-BLDG & 3	NEW CAP REL COSTS-MVBLE 4	EMPLOYEE BEN EFITS 5	SUBTOTAL 5A	ADMINISTRATI VE & GENERAL 6
1 ADMIN & GENERAL		10,275	22,359	48,250	80,884	14,692
2 SKILLED NURSING CARE	665,198			138,907	804,105	146,063
3 PHYSICAL THERAPY	230,735			39,861	270,596	49,153
4 OCCUPATIONAL THERAPY	93,384			19,479	112,863	20,501
5 SPEECH PATHOLOGY	2,097			458	2,555	464
6 MEDICAL SOCIAL SERVICES	4,983			1,034	6,017	1,093
7 HOME HEALTH AIDE	151,084			26,944	178,028	32,338
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	1,147,481	10,275	22,359	274,933	1,455,048	264,304
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
 (2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA COST CENTER	MAINTENANCE & REPAIRS 7	OPERATION OF PLANT 8	LAUNDRY & LI NEN SERVICE 9	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12
1 ADMIN & GENERAL	73,259	16,163				43,991
2 SKILLED NURSING CARE						
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	73,259	16,163				43,991
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
 (2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA 1

HHA COST CENTER	MAINTENANCE OF PERSONNEL 13	NURSING ADMI NISTRATION 14	CENTRAL SERV ICES & SUPPL 15	PHARMACY 16	MEDICAL RECO RDS & LIBRAR 17	SOCIAL SERVI CE 18
1 ADMIN & GENERAL		141,569				
2 SKILLED NURSING CARE						
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						10,599
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)		141,569				10,599
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.

(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA COST CENTER	SUBTOTAL 25	POST STEP DOWN ADJUST 26	SUBTOTAL 27	ALLOCATED HHA A & G 28	TOTAL HHA COSTS 29
1 ADMIN & GENERAL	370,558		370,558		
2 SKILLED NURSING CARE	950,168		950,168	215,430	1,165,598
3 PHYSICAL THERAPY	319,749		319,749	72,496	392,245
4 OCCUPATIONAL THERAPY	133,364		133,364	30,237	163,601
5 SPEECH PATHOLOGY	3,019		3,019	684	3,703
6 MEDICAL SOCIAL SERVICES	17,709		17,709	4,015	21,724
7 HOME HEALTH AIDE	210,366		210,366	47,696	258,062
8 SUPPLIES					
9 DRUGS					
9.20 COST ADMINISTERING DRUGS					
10 DME					
11 HOME DIALYSIS AIDE SVCS					
12 RESPIRATORY THERAPY					
13 PRIVATE DUTY NURSING					
14 CLINIC					
15 HEALTH PROM ACTIVITIES					
16 DAY CARE PROGRAM					
17 HOME DEL MEALS PROGRAM					
18 HOMEMAKER SERVICE					
19 ALL OTHER					
19.50 TELEMEDICINE					
20 TOTAL (SUM OF 1-19) (2)	2,004,933		2,004,933	370,558	2,004,933
21 UNIT COST MULTIPLIER				0.226728	

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.

(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA 1

HHA COST CENTER	NEW CAP REL COSTS-BLDG & (SQUARE FEE T 3)	NEW CAP REL COSTS-MVBLE (SQUARE FEE T 4)	EMPLOYEE BEN EFITS (GROSS SALARIES 5)	RECONCILIATI ON 6A	ADMINISTRATI VE & GENERAL (ACCUM. COST 6)	MAINTENANCE & REPAIRS (TIME SPENT 7)
1 ADMIN & GENERAL	2,628	2,628	178,967		80,884	380
2 SKILLED NURSING CARE			515,234		804,105	
3 PHYSICAL THERAPY			147,854		270,596	
4 OCCUPATIONAL THERAPY			72,252		112,863	
5 SPEECH PATHOLOGY			1,700		2,555	
6 MEDICAL SOCIAL SERVICES			3,834		6,017	
7 HOME HEALTH AIDE			99,940		178,028	
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)	2,628	2,628	1,019,781		1,455,048	380
21 COST TO BE ALLOCATED	10,275	22,359	274,933		264,304	73,259
22 UNIT COST MULTIPLIER	3.909817	8.507991	0.269600		0.181646	192.786842

HHA COST CENTER	OPERATION OF PLANT (SQUARE FEE T 8)	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY 9)	HOUSEKEEPING (HOURS OF S ERVICE 10)	DIETARY (MEALS SERV ED 11)	CAFETERIA (HOURS 12)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED 13)
1 ADMIN & GENERAL	2,628				41,323	
2 SKILLED NURSING CARE						
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)	2,628				41,323	
21 COST TO BE ALLOCATED	16,163				43,991	
22 UNIT COST MULTIPLIER	6.150304				1.064565	

HHA 1

HHA COST CENTER	NURSING ADMINISTRATION (NRSING HOURS	CENTRAL SERVICES & SUPPLIES (COSTED REQUIS.	PHARMACY (COSTED REQUIS.	MEDICAL RECORDS & LIBRARIES (GROSS ARGES	SOCIAL SERVICE (TIME SPENT
	14	15	16	17	18
1 ADMIN & GENERAL	41,323				
2 SKILLED NURSING CARE					
3 PHYSICAL THERAPY					
4 OCCUPATIONAL THERAPY					
5 SPEECH PATHOLOGY					
6 MEDICAL SOCIAL SERVICES					62
7 HOME HEALTH AIDE					
8 SUPPLIES					
9 DRUGS					
9.20 COST ADMINISTERING DRUGS					
10 DME					
11 HOME DIALYSIS AIDE SVCS					
12 RESPIRATORY THERAPY					
13 PRIVATE DUTY NURSING					
14 CLINIC					
15 HEALTH PROM ACTIVITIES					
16 DAY CARE PROGRAM					
17 HOME DEL MEALS PROGRAM					
18 HOMEMAKER SERVICE					
19 ALL OTHER					
19.50 TELEMEDICINE					
20 TOTAL (SUM OF 1-19)	41,323				62
21 COST TO BE ALLOCATED	141,569				10,599
22 UNIT COST MULTIPLIER	3.425913				170.951613

[] TITLE V [X] TITLE XVIII [] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:
 COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

COST PER VISIT COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	PROGRAM VISITS PART A
PATIENT SERVICES		1	2	3	4	5	6
1 SKILLED NURSING	2	1,165,598		1,165,598	5,340	218.28	1,548
2 PHYSICAL THERAPY	3	392,245		392,245	1,983	197.80	596
3 OCCUPATIONAL THERAPY	4	163,601		163,601	578	283.05	244
4 SPEECH PATHOLOGY	5	3,703		3,703	22	168.32	12
5 MEDICAL SOCIAL SERVICES	6	21,724		21,724	38	571.68	11
6 HOME HEALTH AIDE SERVICE	7	258,062		258,062	3,271	78.89	289
7 TOTAL		2,004,933		2,004,933	11,232		2,700

	-----PROGRAM VISITS-----		-----COST OF SERVICES-----		TOTAL PROGRAM COST
	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	
	7	8	PART A 9	PART B 10	11
1 SKILLED NURSING	1,600		337,897	349,248	687,145
2 PHYSICAL THERAPY	701		117,889	138,658	256,547
3 OCCUPATIONAL THERAPY	145		69,064	41,042	110,106
4 SPEECH PATHOLOGY	6		2,020	1,010	3,030
5 MEDICAL SOCIAL SERVICES	15		6,288	8,575	14,863
6 HOME HEALTH AIDE SERVICES	1,073		22,799	84,649	107,448
7 TOTAL	3,540		555,957	623,182	1,179,139

LIMITATION COST COMPUTATION						PROGRAM COST LIMITS	PROGRAM VISITS PART A
PATIENT SERVICES	1	2	3	4	5	6	
8 SKILLED NURSING							
9 PHYSICAL THERAPY							
10 OCCUPATIONAL THERAPY							
11 SPEECH PATHOLOGY							
12 MEDICAL SOCIAL SERVICES							
13 HOME HEALTH AIDE SERVICE							
14 TOTAL							

	-----PROGRAM VISITS-----		-----COST OF SERVICES-----		TOTAL PROGRAM COST
	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	
	7	8	PART A 9	PART B 10	11
8 SKILLED NURSING					
9 PHYSICAL THERAPY					
10 OCCUPATIONAL THERAPY					
11 SPEECH PATHOLOGY					
12 MEDICAL SOCIAL SERVICES					
13 HOME HEALTH AIDE SERVICE					
14 TOTAL					

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET H-6
 I HHA NO: I TO 12/31/2010 I PARTS I II & III
 I 15-7153 I HHA 1

[] TITLE V [X] TITLE XVIII [] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:

COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

SUPPLIES AND EQUIPMENT COST COMPUTATION	FROM WKST H-5 PART I COL. 29, OTHER PATIENT SERVICES LINE:	FACILITY COSTS (FROM WKST H-5 PART I) 1	SHARED ANCILLARY COSTS (FROM PART II) 2	TOTAL HHA COSTS 3	TOTAL CHARGES 4	RATIO 5	PROGRAM COVERED CHARGES PART A 6
15 COST OF MEDICAL SUPPLIES	8.00				72,040		17,965
16 COST OF DRUGS	9.00						
16.20 COST OF DRUGS	9.20						

	PROGRAM COVERED CHARGES -----PART B-----		-----COST OF SERVICES----- -----PART B-----		
	NOT SUBJECT TO DEDUCT & COINSUR 7	SUBJECT TO DEDUCT & COINSUR 8	PART A 9	NOT SUBJECT TO DEDUCT & COINSUR 10	SUBJECT TO DEDUCT & COINSUR 11
15 COST OF MEDICAL SUPPLIES		54,075			
16 COST OF DRUGS					
16.20 COST OF DRUGS					

PER BENEFICIARY COST
LIMITATION:

	MSA NUMBER 1	AMOUNT 2
162 PROGRAM UNDUP CENSUS FROM WRKST S-4		
17 PER BENE COST LIMITATION (FRM FI)		
18 PER BENE COST LIMITATION (LN 17*18)		

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

	FROM WKST C PT I, COL 9	COST TO CHARGE RATIO 1	TOTAL HHA CHARGES 2	HHA SHARED ANCILLARY COSTS 3	TRANSFER TO PART I AS INDICATED 4
1 PHYSICAL THERAPY	50	.535717			COL 2, LN 2
2 OCCUPATIONAL THERAPY	51	.624670			COL 2, LN 3
3 SPEECH PATHOLOGY	52	.819512			COL 2, LN 4
4 MEDICAL SUPPLIES CHARGED TO PATIENT	55	.734833			COL 2, LN 15
4.30 IMPL. DEV. CHARGED TO PATIENT	55.30	.892324			
5 DRUGS CHARGED TO PATIENTS	56	.460234			COL 2, LN 16

PART III - OUTPATIENT THERAPY REDUCTION COMPUTATION

	FROM PART I, COL 5 1	COST PER VISIT 2	----- PART B SERVICES SUBJECT TO DEDUCTIBLES AND COINSURANCE -----		----- PROGRAM COSTS -----		PROG VISITS ON OR AFTER 1/1/1999 5
			PRIOR 1/1/1998 3	1/1/1998 TO 12/31/1998 4	PRIOR 1/1/1998 3	1/1/1998 TO 12/31/1998 4	
1 PHYSICAL THERAPY		197.80	2.01	3	3.01	4	
2 OCCUPATIONAL THERAPY		283.05					
3 SPEECH PATHOLOGY		168.32					
4 TOTAL (SUM OF LINES 1-3)							

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/31/2011
 I 15-1332 I FROM 1/ 1/2010 I WORKSHEET H-7
 I HHA NO: I TO 12/31/2010 I PARTS I & II
 I 15-7153 I I

TITLE XVIII HHA 1

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES
 PART A

PART B NOT SUBJECT TO DED & COINS 2
 PART B SUBJECT TO DED & COINS 3

- 1 REASONABLE COST OF SERVICES
- 2 TOTAL CHARGES
- 3 CUSTOMARY CHARGES
- 4 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS
- 5 AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(B)
- 6 RATIO OF LINE 3 TO 4 (NOT TO EXCEED 1.000000)
- 7 TOTAL CUSTOMARY CHARGES
- 8 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST
- 9 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES
- 10 PRIMARY PAYOR AMOUNTS

1

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

PART A SERVICES 1
 PART B SERVICES 2

10	TOTAL REASONABLE COST		
10.01	TOTAL PPS REIMBURSEMENT-FULL EPISODES WITHOUT OUTLIERS	407,581	469,176
10.02	TOTAL PPS REIMBURSEMENT-FULL EPISODES WITH OUTLIERS	1,564	5,904
10.03	TOTAL PPS REIMBURSEMENT-LUPA EPISODES	11,050	19,821
10.04	TOTAL PPS REIMBURSEMENT-PEP EPISODES	2,814	5,046
10.05	TOTAL PPS REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.06	TOTAL PPS REIMBURSEMENT-SCIC EPISODES		
10.07	TOTAL PPS OUTLIER REIMBURSEMENT-FULL EPISODES WITH OUTLIERS	3,342	747
10.08	TOTAL PPS OUTLIER REIMBURSEMENT-PEP EPISODES		206
10.09	TOTAL PPS OUTLIER REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.10	TOTAL PPS OUTLIER REIMBURSEMENT-SCIC EPISODES		
10.11	TOTAL OTHER PAYMENTS		
10.12	DME PAYMENTS		
10.13	OXYGEN PAYMENTS		
10.14	PROSTHETIC AND ORTHOTIC PAYMENTS		
11	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)		
12	SUBTOTAL	426,351	500,900
13	EXCESS REASONABLE COST		
14	SUBTOTAL	426,351	500,900
15	COINSURANCE BILLED TO PROGRAM PATIENTS		
16	NET COST	426,351	500,900
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL COSTS - CURRENT COST REPORTING PERIOD	426,351	500,900
19	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
20	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR DECREASE IN MEDICARE UTILIZATION		
21	OTHER ADJUSTMENTS (SPECIFY)		1
22	SUBTOTAL	426,351	500,901
23	SEQUESTRATION ADJUSTMENT		
24	SUBTOTAL	426,351	500,901
25	INTERIM PAYMENTS	426,351	500,901
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE PROVIDER/PROGRAM		
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II SECTION 115.2		

TITLE XVIII HHA 1

DESCRIPTION	P A R T A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER	1	426,351	3	500,901
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		
ADJUSTMENTS TO PROVIDER		.02		
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		
ADJUSTMENTS TO PROGRAM		.99		
4 TOTAL INTERIM PAYMENTS		NONE		NONE
		426,351		500,901
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		
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		NONE		NONE
7 TOTAL MEDICARE PROGRAM LIABILITY		426,351		500,901

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 CAPITAL PAYMENT

TITLE XIX HOSPITAL

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS	
	CAPITAL FEDERAL AMOUNT	
2	CAPITAL DRG OTHER THAN OUTLIER	
3	CAPITAL DRG OUTLIER PAYMENTS PRIOR TO 10/01/1997	
3 .01	CAPITAL DRG OUTLIER PAYMENTS AFTER 10/01/1997	
	INDIRECT MEDICAL EDUCATION ADJUSTMENT	
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS	.00
	IN THE COST REPORTING PERIOD	
4 .01	NUMBER OF INTERNS AND RESIDENTS	.00
	(SEE INSTRUCTIONS)	
4 .02	INDIRECT MEDICAL EDUCATION PERCENTAGE	.00
4 .03	INDIRECT MEDICAL EDUCATION ADJUSTMENT	
	(SEE INSTRUCTIONS)	
5	PERCENTAGE OF SSI RECEIPT PATIENT DAYS TO	.00
	MEDICARE PART A PATIENT DAYS	
5 .01	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL	.00
	DAYS REPORTED ON S-3, PART I	
5 .02	SUM OF 5 AND 5.01	.00
5 .03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE	.00
5 .04	DISPROPORTIONATE SHARE ADJUSTMENT	
6	TOTAL PROSPECTIVE CAPITAL PAYMENTS	

PART II - HOLD HARMLESS METHOD

1	NEW CAPITAL	
2	OLD CAPITAL	
3	TOTAL CAPITAL	
4	RATIO OF NEW CAPITAL TO OLD CAPITAL	.000000
5	TOTAL CAPITAL PAYMENTS UNDER 100% FEDERAL RATE	
6	REDUCTION FACTOR FOR HOLD HARMLESS PAYMENT	
7	REDUCED OLD CAPITAL AMOUNT	
8	HOLD HARMLESS PAYMENT FOR NEW CAPITAL	
9	SUBTOTAL	
10	PAYMENT UNDER HOLD HARMLESS	

PART III - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST	
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST	
3	TOTAL INPATIENT PROGRAM CAPITAL COST	
4	CAPITAL COST PAYMENT FACTOR	
5	TOTAL INPATIENT PROGRAM CAPITAL COST	

PART IV - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS	
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY	
	CIRCUMSTANCES	
3	NET PROGRAM INPATIENT CAPITAL COSTS	
4	APPLICABLE EXCEPTION PERCENTAGE	.00
5	CAPITAL COST FOR COMPARISON TO PAYMENTS	
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY	.00
	CIRCUMSTANCES	
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL	
	FOR EXTRAORDINARY CIRCUMSTANCES	
8	CAPITAL MINIMUM PAYMENT LEVEL	
9	CURRENT YEAR CAPITAL PAYMENTS	
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT	
	LEVEL TO CAPITAL PAYMENTS	
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT	
	LEVEL OVER CAPITAL PAYMENT	
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL	
	TO CAPITAL PAYMENTS	
13	CURRENT YEAR EXCEPTION PAYMENT	
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT	
	LEVEL OVER CAPITAL PAYMENT FOR FOLLOWING PERIOD	
15	CUR YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT	
16	CURRENT YEAR OPERATING AND CAPITAL COSTS	
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT	
	(SEE INSTRUCTIONS)	