

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

WORKSHEET 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	15-3039	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: 5/27/2011 TIME 14:05

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:
 HRHS SPECIALTY HOSPITAL 15-3039
 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.

 ECR ENCRYPTION INFORMATION
 DATE: 5/27/2011 TIME 14:05

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PI ENCRYPTION INFORMATION
 DATE: 5/27/2011 TIME 14:05

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 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	-5,594	31,572	0	
100	TOTAL	0	-5,594	31,572	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 AND HOSPITAL HEALTH CARE COMPLEX ADDRESS
 1 STREET: 829 N. DIXON ROAD P.O. BOX:
 1.01 CITY: KOKOMO STATE: IN ZIP CODE: 46901- COUNTY: HOWARD

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;					PAYMENT SYSTEM (P,T,O OR N)		
COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	V	XVIII	XIX
0	1	2	2.01	3	4	5	6
02.00	HOSPITAL	HRHS SPECIALTY HOSPITAL	15-3039	4/ 1/2004	N	P	O

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

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL
 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 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. 1 N Y 15
- 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 1
- 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 1
- 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. 3 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?
 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 WEIGHTED 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. N / /
 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) N
 30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH?
 SEE 42 CFR 413.70
 30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF
 PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS) N
 30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE
 SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST
 BE ON OR AFTER 12/21/2000). N
 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

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

- 36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) V XVIII XIX
1 2 3
- 36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS) N Y 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? Y
- 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
- 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
- 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 NHCMP 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

- 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: 0
 PAID LOSSES: 0
 AND/OR SELF INSURANCE: 0
- 54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N
- 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

		DATE 0	Y OR N 1	LIMIT 2	Y OR N 3	FEE 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.		Y			
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).		N		0	
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.

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). / /

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.

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
I 15-3039 I FROM 1/ 1/2010 I WORKSHEET S-3
I I TO 12/31/2010 I PART I

COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH N/A	I/P DAYS / TITLE	O/P VISITS / TITLE	TRIPS / TOTAL
	1	2	2.01	V	XVIII	XIX
1 ADULTS & PEDIATRICS	30	10,950			5,642	21
2 HMO						77
2 01 HMO - (IRF PPS SUBPROVIDER)						
3 ADULTS & PED-SB SNF						
4 ADULTS & PED-SB NF						
5 TOTAL ADULTS AND PEDS	30	10,950			5,642	21
12 TOTAL	30	10,950			5,642	21
13 RPCH VISITS						
25 TOTAL	30					
26 OBSERVATION BED DAYS						
27 AMBULANCE TRIPS						
28 EMPLOYEE DISCOUNT DAYS						
28 01 EMP DISCOUNT DAYS -IRF						
29 LABOR & DELIVERY DAYS						

COMPONENT	TITLE XIX ADMITTED	I/P DAYS / OBSERVATION BEDS NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	TRIPS / TOTAL OBSERVATION BEDS ADMITTED	DISCHARGES / TOTAL OBSERVATION BEDS NOT ADMITTED	INTERNS & RES. LESS I&R REPL NON-PHYS ANES
	5.01	5.02	6	6.01	6.02	7
1 ADULTS & PEDIATRICS			6,558			8
2 HMO						
2 01 HMO - (IRF PPS SUBPROVIDER)						
3 ADULTS & PED-SB SNF						
4 ADULTS & PED-SB NF						
5 TOTAL ADULTS AND PEDS			6,558			
12 TOTAL			6,558			
13 RPCH VISITS						
25 TOTAL						
26 OBSERVATION BED DAYS						
27 AMBULANCE TRIPS						
28 EMPLOYEE DISCOUNT DAYS						
28 01 EMP DISCOUNT DAYS -IRF						
29 LABOR & DELIVERY DAYS						

COMPONENT	I & R FTES NET	FULL TIME EMPLOYEES ON PAYROLL	EQUIV NONPAID WORKERS	DISCHARGES TITLE V	DISCHARGES TITLE XVIII	DISCHARGES TITLE XIX	TOTAL ALL PATIENTS
	9	10	11	12	13	14	15
1 ADULTS & PEDIATRICS					520	12	625
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
12 TOTAL		149.48			520	12	625
13 RPCH VISITS							
25 TOTAL		149.48					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:
I 15-3039
I

I PERIOD:
I FROM 1/ 1/2010
I TO 12/31/2010
I PREPARED 5/27/2011
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					
1	0100 OLD CAP REL COSTS-BLDG & FIXT		211,287	211,287	17,995	229,282
1.01	0101 OLD CAP REL COSTS-BLDG & FIXT		33,226	33,226		33,226
5	0500 EMPLOYEE BENEFITS	28,327	1,039,809	1,068,136	-1,087	1,067,049
6	0600 ADMINISTRATIVE & GENERAL	1,099,385	1,131,198	2,230,583	-18,567	2,212,016
8	0800 OPERATION OF PLANT	360,947	1,331,361	1,692,308	-977	1,691,331
9	0900 LAUNDRY & LINEN SERVICE		40,904	40,904		40,904
10	1000 HOUSEKEEPING	71,728	37,998	109,726	-1,158	108,568
11	1100 DIETARY	174,424	129,107	303,531	-2,663	300,868
12	1200 CAFETERIA				2,661	2,661
14	1400 NURSING ADMINISTRATION				95,502	95,502
17	1700 MEDICAL RECORDS & LIBRARY	215,946	31,646	247,592		247,592
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	1,187,942	657,151	1,845,093	-423,114	1,421,979
	ANCILLARY SRVC COST CNTRS					
41	4100 RADIOLOGY-DIAGNOSTIC	4,190	10,470	14,660	31,984	46,644
41.02	4101 IMAGING CENTER					
44	4400 LABORATORY		2,158	2,158	189,880	192,038
49	4900 RESPIRATORY THERAPY	260,000	64,421	324,421	-19,035	305,386
50	5000 PHYSICAL THERAPY	2,932,550	858,635	3,791,185	-15,665	3,775,520
53	5300 ELECTROCARDIOLOGY				397	397
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	37,825	6,531	44,356	186,495	230,851
56	5600 DRUGS CHARGED TO PATIENTS	239,580	375,685	615,265	-2,764	612,501
	OUTPAT SERVICE COST CNTRS					
61	6100 EMERGENCY					
63	4950 OTHER OUTPATIENT SERVICE COST CENTER					
63.02	4041 NEUROPSYCH OFFICE	79,910	12,983	92,893		92,893
63.03	4042 SLEEP LAB	390,250	165,333	555,583	-39,713	515,870
63.04	4043 PHYSICIANS OFFICE	45,567	8,040	53,607	-171	53,436
	SPEC PURPOSE COST CENTERS					
95	SUBTOTALS	7,128,571	6,147,943	13,276,514	-0-	13,276,514
101	NONREIMBURS COST CENTERS					
	TOTAL	7,128,571	6,147,943	13,276,514	-0-	13,276,514

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
I 15-3039 I FROM 1/ 1/2010 I WORKSHEET A
I I TO 12/31/2010 I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
1 0100	OLD CAP REL COSTS-BLDG & FIXT		229,282
1.01 0101	OLD CAP REL COSTS-BLDG & FIXT		33,226
5 0500	EMPLOYEE BENEFITS		1,067,049
6 0600	ADMINISTRATIVE & GENERAL	358,557	2,570,573
8 0800	OPERATION OF PLANT		1,691,331
9 0900	LAUNDRY & LINEN SERVICE		40,904
10 1000	HOUSEKEEPING		108,568
11 1100	DIETARY	-522	300,346
12 1200	CAFETERIA		2,661
14 1400	NURSING ADMINISTRATION		95,502
17 1700	MEDICAL RECORDS & LIBRARY	-3,527	244,065
	INPAT ROUTINE SRVC CNTRS		
25 2500	ADULTS & PEDIATRICS	-3,890	1,418,089
	ANCILLARY SRVC COST CNTRS		
41 4100	RADIOLOGY-DIAGNOSTIC	-28,676	17,968
41.02 4101	IMAGING CENTER		
44 4400	LABORATORY	-176,530	15,508
49 4900	RESPIRATORY THERAPY	-8,974	296,412
50 5000	PHYSICAL THERAPY	-24,728	3,750,792
53 5300	ELECTROCARDIOLOGY	-331	66
55 5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	-2,621	228,230
56 5600	DRUGS CHARGED TO PATIENTS	-175	612,326
	OUTPAT SERVICE COST CNTRS		
61 6100	EMERGENCY		
63 4950	OTHER OUTPATIENT SERVICE COST CENTER		
63.02 4041	NEUROPSYCH OFFICE		92,893
63.03 4042	SLEEP LAB	-30,711	485,159
63.04 4043	PHYSICIANS OFFICE	-1,820	51,616
	SPEC PURPOSE COST CENTERS		
95	SUBTOTALS	76,052	13,352,566
	NONREIMBURS COST CENTERS		
101	TOTAL	76,052	13,352,566

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
1	OLD CAP REL COSTS-BLDG & FIXT	0100	
1.01	OLD CAP REL COSTS-BLDG & FIXT	0101	OLD CAP REL COSTS-BLDG & FIXT
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
	ANCILLARY SRVC COST		
41	RADIOLOGY-DIAGNOSTIC	4100	
41.02	IMAGING CENTER	4101	RADIOLOGY-DIAGNOSTIC
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.02	NEUROPSYCH OFFICE	4041	FAMILY PRACTICE
63.03	SLEEP LAB	4042	FAMILY PRACTICE
63.04	PHYSICIANS OFFICE	4043	FAMILY PRACTICE
	SPEC PURPOSE COST CE		
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
153039	FROM 1/ 1/2010	5/27/2011
	TO 12/31/2010	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	----- INCREASE -----				
	CODE (1)	COST CENTER 2	LINE NO 3	SALARY 4	OTHER 5
1 SUPPLY RECLASS	A	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		168,029
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12 PHARMACY RECLASS	B	DRUGS CHARGED TO PATIENTS	56		676
13					
14					
15					
16					
17 CAFETERIA RECLASS	C	CAFETERIA	12	1,529	1,132
18 NURSING ADMIN RECLASS	D	NURSING ADMINISTRATION	14	95,502	
19 INSURANCE RECLASS	E	OLD CAP REL COSTS-BLDG & FIXT	1		17,995
20 PURCHASED SERVICES RECLASS	F	RADIOLOGY-DIAGNOSTIC	41		31,984
21		LABORATORY	44		189,880
22		RESPIRATORY THERAPY	49		10,735
23		PHYSICAL THERAPY	50		6,000
24		ELECTROCARDIOLOGY	53		397
25		MEDICAL SUPPLIES CHARGED TO PATIENTS	55		18,478
26		DRUGS CHARGED TO PATIENTS	56		414
36 TOTAL RECLASSIFICATIONS				97,031	445,720

(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: 153039	PERIOD: FROM 1/ 1/2010 TO 12/31/2010	PREPARED 5/27/2011 WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 1	DECREASE			A-7 REF 10
			LINE NO 7	SALARY 8	OTHER 9	
1 SUPPLY RECLASS	A	6	5		558	
2			6		572	
3			8		977	
4			10		1,158	
5			11		2	
6			25		69,648	
7			49		29,770	
8			50		21,609	
9			56		3,854	
10			63.03		39,713	
11			63.04		168	
12 PHARMACY RECLASS	B		5		529	
13			25		76	
14			50		56	
15			55		12	
16			63.04		3	
17 CAFETERIA RECLASS	C		11	1,529	1,132	
18 NURSING ADMIN RECLASS	D		25	95,502		
19 INSURANCE RECLASS	E		6		17,995	12
20 PURCHASED SERVICES RECLASS	F		25		257,888	
21						
22						
23						
24						
25						
26						
36 TOTAL RECLASSIFICATIONS				97,031	445,720	

(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
153039	FROM 1/ 1/2010	5/27/2011
	TO 12/31/2010	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : SUPPLY RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	168,029	EMPLOYEE BENEFITS	5	558	
2.00			0	ADMINISTRATIVE & GENERAL	6	572	
3.00			0	OPERATION OF PLANT	8	977	
4.00			0	HOUSEKEEPING	10	1,158	
5.00			0	DIETARY	11	2	
6.00			0	ADULTS & PEDIATRICS	25	69,648	
7.00			0	RESPIRATORY THERAPY	49	29,770	
8.00			0	PHYSICAL THERAPY	50	21,609	
9.00			0	DRUGS CHARGED TO PATIENTS	56	3,854	
10.00			0	SLEEP LAB	63.03	39,713	
11.00			0	PHYSICIANS OFFICE	63.04	168	
TOTAL RECLASSIFICATIONS FOR CODE A			168,029				168,029

RECLASS CODE: B
EXPLANATION : PHARMACY RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	DRUGS CHARGED TO PATIENTS	56	676	EMPLOYEE BENEFITS	5	529	
2.00			0	ADULTS & PEDIATRICS	25	76	
3.00			0	PHYSICAL THERAPY	50	56	
4.00			0	MEDICAL SUPPLIES CHARGED TO PA	55	12	
5.00			0	PHYSICIANS OFFICE	63.04	3	
TOTAL RECLASSIFICATIONS FOR CODE B			676				676

RECLASS CODE: C
EXPLANATION : CAFETERIA RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	CAFETERIA	12	2,661	DIETARY	11	2,661	
TOTAL RECLASSIFICATIONS FOR CODE C			2,661				2,661

RECLASS CODE: D
EXPLANATION : NURSING ADMIN RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NURSING ADMINISTRATION	14	95,502	ADULTS & PEDIATRICS	25	95,502	
TOTAL RECLASSIFICATIONS FOR CODE D			95,502				95,502

RECLASS CODE: E
EXPLANATION : INSURANCE RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	OLD CAP REL COSTS-BLDG & FIXT	1	17,995	ADMINISTRATIVE & GENERAL	6	17,995	
TOTAL RECLASSIFICATIONS FOR CODE E			17,995				17,995

RECLASS CODE: F
EXPLANATION : PURCHASED SERVICES RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	RADIOLOGY-DIAGNOSTIC	41	31,984	ADULTS & PEDIATRICS	25	257,888	
2.00	LABORATORY	44	189,880			0	
3.00	RESPIRATORY THERAPY	49	10,735			0	
4.00	PHYSICAL THERAPY	50	6,000			0	
5.00	ELECTROCARDIOLOGY	53	397			0	
6.00	MEDICAL SUPPLIES CHARGED TO PA	55	18,478			0	
7.00	DRUGS CHARGED TO PATIENTS	56	414			0	
TOTAL RECLASSIFICATIONS FOR CODE F			257,888				257,888

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		16,570		16,570		16,570	
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN	73,573	137,447		137,447		211,020	
5	FIXED EQUIPMENT	58,455	60,657		60,657		119,112	
6	MOVABLE EQUIPMENT	1,153,804	149,908		149,908	5,660	1,298,052	
7	SUBTOTAL	1,285,832	364,582		364,582	5,660	1,644,754	
8	RECONCILING ITEMS							
9	TOTAL	1,285,832	364,582		364,582	5,660	1,644,754	

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							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT							
7	SUBTOTAL							
8	RECONCILING ITEMS							
9	TOTAL							

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
1 OLD CAP REL COSTS-BL								
1 01 OLD CAP REL COSTS-BL								
5 TOTAL				1.000000				

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
*	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BL	211,287			17,995			229,282
1 01 OLD CAP REL COSTS-BL	33,226						33,226
5 TOTAL	244,513			17,995			262,508

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

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
*	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BL	211,287						211,287
1 01 OLD CAP REL COSTS-BL	33,226						33,226
5 TOTAL	244,513						244,513

* 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 15-3039
I

I PERIOD: I PREPARED 5/27/2011
I FROM 1/ 1/2010 I WORKSHEET A-8
I TO 12/31/2010 I

DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST. A-7 REF. 5
			COST CENTER 3	LINE NO 4	
1 INVST INCOME-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3 INVST INCOME-NEW BLDGS AND FIXTURES			**COST CENTER DELETED**	3	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			**COST CENTER DELETED**	4	
5 INVESTMENT INCOME-OTHER					
6 TRADE, QUANTITY AND TIME DISCOUNTS					
7 REFUNDS AND REBATES OF EXPENSES					
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9 TELEPHONE SERVICES					
10 TELEVISION AND RADIO SERVICE					
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-25,871			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1	265,550			
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS					
17 RENTAL OF QTRS TO EMPLOYEE AND OTHERS					
18 SALE OF MED AND SURG SUPPLIES					
19 SALE OF DRUGS TO OTHER THAN PATIENTS					
20 SALE OF MEDICAL RECORDS & ABSTRACTS					
21 NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22 VENDING MACHINES	B	-101	ADMINISTRATIVE & GENERAL	6	
23 INCOME FROM IMPOSITION OF INTEREST					
24 INTRST EXP ON MEDICARE OVERPAYMENTS					
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28 UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			**COST CENTER DELETED**	3	
32 DEPRECIATION-NEW MOVABLE EQUIP			**COST CENTER DELETED**	4	
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34 PHYSICIANS' ASSISTANT					
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37 HRSC GENERAL ACCT MISCELLANEOUS REVE	B	-249	ADMINISTRATIVE & GENERAL	6	
38 HRSC REPLAY OTHER RE REPLAY AFTER CA	B	-13,883	ADMINISTRATIVE & GENERAL	6	
39 HRSC REPLAY OTHER RE OTHER OPERATING	B	-53,751	ADMINISTRATIVE & GENERAL	6	
40 HRSC OTHER OPER. REV MISC REVENUE	B	-6,671	ADMINISTRATIVE & GENERAL	6	
41 HRSC OTHER OPER. REV OTHER OPERATING	B	-23,986	ADMINISTRATIVE & GENERAL	6	
42 HRSC DIETARY NON-FOO SALES	B	-522	DIETARY	11	
43 HRSC MEDREC SALES MISC REVENUE	B	-3,527	MEDICAL RECORDS & LIBRARY	17	
44 HRSC OCCUPATIONAL TH MISCELLANEOUS R	B	-4,015	PHYSICAL THERAPY	50	
45 HRSC REPLAY OTHER RE REPLAY DME REVE	B	-11,585	PHYSICAL THERAPY	50	
46 HRSC REPLAY OTHER RE PHYS OFF & OTH	B	-1,820	PHYSICIANS OFFICE	63.04	
47 CHARITABLE DONATIONS	A	-900	ADMINISTRATIVE & GENERAL	6	
48 ADVERTISING & PROMOTION	A	-31,492	ADMINISTRATIVE & GENERAL	6	
49 ADVERTISING & PROMOTION	A	-6,285	PHYSICAL THERAPY	50	
49.01 ADVERTISING & PROMOTION	A	-4,840	SLEEP LAB	63.03	
49.02					
49.03					
49.04					
49.05					
50 TOTAL (SUM OF LINES 1 THRU 49)		76,052			

(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	6	ADMINISTRATIVE & GENERAL	681,086	191,496	489,590	
2	25	ADULTS & PEDIATRICS	1,469	5,359	-3,890	
3	41	RADIOLOGY-DIAGNOSTIC	3,099	31,775	-28,676	
4	44	LABORATORY	12,429	188,959	-176,530	
4.01	49	RESPIRATORY THERAPY	1,761	10,735	-8,974	
4.02	50	PHYSICAL THERAPY	3,157	6,000	-2,843	
4.03	53	ELECTROCARDIOLOGY	35	366	-331	
4.04	55	MEDICAL SUPPLIES CHARGED	2,387	5,008	-2,621	
4.05	56	DRUGS CHARGED TO PATIENTS	197	372	-175	
5		TOTALS	705,620	440,070	265,550	

* 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	60.00	HOWARD REGIONAL HEALTH SY	0.00	
2		0.00		0.00	
3		0.00		0.00	
4		0.00		0.00	
5		0.00		0.00	

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
 - B. CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
 - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION.
 - D. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS A FINANCIAL INTEREST IN RELATED ORGANIZATION.
 - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
 - F. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
 - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY.
MISC SERVICES

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO:
I 15-3039
I

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

I PREPARED 5/27/2011
I WORKSHEET A-8-2
I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
63	3 SLEEP LAB	44,000		44,000	171,400	220	18,129	906
101	TOTAL	44,000		44,000		220	18,129	906

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO:
I 15-3039
I

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

I PREPARED 5/27/2011
I WORKSHEET A-8-2
I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF COL 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COL 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
10	11	12	13	14	15	16	17	18
1	63 3 SLEEP LAB					18,129	25,871	25,871
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL					18,129	25,871	25,871

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-3039 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				
1	OLD CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEET	ENTERED
1.01	OLD CAP REL COSTS-BLDG & FIXT	9	DIRECT	PT ALLOCATIO	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	1	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	1	SQUARE	FEET	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	11	FTE'S		ENTERED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME	SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-3039 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	OLD CAP REL C OSTS-BLDG &	OLD CAP REL C OSTS-BLDG &	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
	0	1	1.01	5	5a.00	6	8
001 GENERAL SERVICE COST CNTR							
001 01 OLD CAP REL COSTS-BLDG &	229,282	229,282					
005 EMPLOYEE BENEFITS	33,226		33,226				
006 ADMINISTRATIVE & GENERAL	1,067,049	791		1,067,840			
008 OPERATION OF PLANT	2,570,573	20,578		165,342	2,756,493	2,756,493	
009 LAUNDRY & LINEN SERVICE	1,691,331	86,898		54,285	1,832,514	476,716	2,309,230
010 HOUSEKEEPING	40,904	2,888			43,792	11,392	55,109
011 DIETARY	108,568	1,820		10,788	121,176	31,523	34,721
012 CAFETERIA	300,346	23,413		26,003	349,762	90,988	446,777
014 NURSING ADMINISTRATION	2,661			230	2,891	752	
017 MEDICAL RECORDS & LIBRARY	95,502	1,321		14,363	111,186	28,924	25,217
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	244,065	1,406		32,477	277,948	72,306	26,827
041 ANCILLARY SRVC COST CNTRS RADIOLOGY-DIAGNOSTIC	1,418,089	42,473		164,298	1,624,860	422,696	810,468
041 02 IMAGING CENTER	17,968	273		630	18,871	4,909	5,212
044 LABORATORY	15,508				15,508	4,034	
049 RESPIRATORY THERAPY	296,412	386		39,103	335,901	87,382	7,358
050 PHYSICAL THERAPY	3,750,792	31,073	33,226	441,037	4,256,128	1,107,202	592,944
053 ELECTROCARDIOLOGY	66				66	17	
055 MEDICAL SUPPLIES CHARGED	228,230	4,370		5,689	238,289	61,989	83,392
056 DRUGS CHARGED TO PATIENTS	612,326	2,237		36,032	650,595	169,248	42,693
061 OUTPAT SERVICE COST CNTRS EMERGENCY							
063 OTHER OUTPATIENT SERVICE							
063 02 NEUROPSYCH OFFICE	92,893	1,860		12,018	106,771	27,776	35,488
063 03 SLEEP LAB	485,159	2,225		58,692	546,076	142,058	42,463
063 04 PHYSICIANS OFFICE	51,616	5,270		6,853	63,739	16,581	100,561
095 SPEC PURPOSE COST CENTERS SUBTOTALS	13,352,566	229,282	33,226	1,067,840	13,352,566	2,756,493	2,309,230
101 NONREIMBURS COST CENTERS CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	13,352,566	229,282	33,226	1,067,840	13,352,566	2,756,493	2,309,230

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-3039 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL RECOR DS & LIBRARY	SUBTOTAL
	9	10	11	12	14	17	25
001 GENERAL SERVICE COST CNTR							
001 01 OLD CAP REL COSTS-BLDG &							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE	110,293						
010 HOUSEKEEPING		187,420					
011 DIETARY		37,729	925,256				
012 CAFETERIA				3,643			
014 NURSING ADMINISTRATION		2,129		78	167,534		
017 MEDICAL RECORDS & LIBRARY		2,265		249		379,595	
025 INPAT ROUTINE SRVC CNTRS							
ADULTS & PEDIATRICS	110,293	68,442	925,256	893	100,520	113,879	4,177,307
041 ANCILLARY SRVC COST CNTRS							
041 02 RADIOLOGY-DIAGNOSTIC		440		2	8,377		37,811
044 IMAGING CENTER							
049 LABORATORY					8,377		27,919
050 RESPIRATORY THERAPY		621		167	16,753	37,960	486,142
053 PHYSICAL THERAPY		50,072		1,746	25,130	189,796	6,223,018
055 ELECTROCARDIOLOGY							83
056 MEDICAL SUPPLIES CHARGED		7,042		34			390,746
OUTPAT SERVICE COST CNTRS		3,605		104			866,245
061 EMERGENCY							
063 OTHER OUTPATIENT SERVICE							
063 02 NEUROPSYCH OFFICE		2,997		43	8,377	37,960	219,412
063 03 SLEEP LAB		3,586		290			734,473
063 04 PHYSICIANS OFFICE		8,492		37			189,410
095 SPEC PURPOSE COST CENTERS							
SUBTOTALS	110,293	187,420	925,256	3,643	167,534	379,595	13,352,566
101 NONREIMBURS COST CENTERS							
102 CROSS FOOT ADJUSTMENT							
103 NEGATIVE COST CENTER							
TOTAL	110,293	187,420	925,256	3,643	167,534	379,595	13,352,566

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-3039 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	I&R COST POST STEP-DOWN ADJ	TOTAL
	26	27
GENERAL SERVICE COST CNTR		
001 OLD CAP REL COSTS-BLDG &		
001 01 OLD CAP REL COSTS-BLDG &		
005 EMPLOYEE BENEFITS		
006 ADMINISTRATIVE & GENERAL		
008 OPERATION OF PLANT		
009 LAUNDRY & LINEN SERVICE		
010 HOUSEKEEPING		
011 DIETARY		
012 CAFETERIA		
014 NURSING ADMINISTRATION		
017 MEDICAL RECORDS & LIBRARY		
INPAT ROUTINE SRVC CNTRS		
025 ADULTS & PEDIATRICS		4,177,307
ANCILLARY SRVC COST CNTRS		
041 RADIOLOGY-DIAGNOSTIC		37,811
041 02 IMAGING CENTER		
044 LABORATORY		27,919
049 RESPIRATORY THERAPY		486,142
050 PHYSICAL THERAPY		6,223,018
053 ELECTROCARDIOLOGY		83
055 MEDICAL SUPPLIES CHARGED		390,746
056 DRUGS CHARGED TO PATIENTS		866,245
OUTPAT SERVICE COST CNTRS		
061 EMERGENCY		
063 OTHER OUTPATIENT SERVICE		
063 02 NEUROPSYCH OFFICE		219,412
063 03 SLEEP LAB		734,473
063 04 PHYSICIANS OFFICE		189,410
SPEC PURPOSE COST CENTERS		
095 SUBTOTALS		13,352,566
NONREIMBURS COST CENTERS		
101 CROSS FOOT ADJUSTMENT		
102 NEGATIVE COST CENTER		
103 TOTAL		13,352,566

ALLOCATION OF OLD CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-3039 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART II

COST CENTER DESCRIPTION	DIR ASSGND OLD CAPITAL REL COSTS 0	OLD CAP REL C OSTS-BLDG & 1	OLD CAP REL C OSTS-BLDG & 1.01	SUBTOTAL 4a	EMPLOYEE FITS 5	BENE E & GENERAL 6	ADMINISTRATIV E & GENERAL 6	OPERATION OF PLANT 8
001 GENERAL SERVICE COST CNTR								
001 01 OLD CAP REL COSTS-BLDG &								
005 EMPLOYEE BENEFITS		791		791	791			
006 ADMINISTRATIVE & GENERAL		20,578		20,578	122	20,700		
008 OPERATION OF PLANT		86,898		86,898	40	3,581		90,519
009 LAUNDRY & LINEN SERVICE		2,888		2,888		86		2,160
010 HOUSEKEEPING		1,820		1,820	8	237		1,361
011 DIETARY		23,413		23,413	19	683		17,513
012 CAFETERIA						6		
014 NURSING ADMINISTRATION		1,321		1,321	11	217		988
017 MEDICAL RECORDS & LIBRARY		1,406		1,406	24	543		1,052
025 INPAT ROUTINE SRVC CNTRS								
ADULTS & PEDIATRICS		42,473		42,473	121	3,175		31,771
041 ANCILLARY SRVC COST CNTRS								
RADIOLOGY-DIAGNOSTIC		273		273		37		204
041 02 IMAGING CENTER								
044 LABORATORY						30		
049 RESPIRATORY THERAPY		386		386	29	656		288
050 PHYSICAL THERAPY		31,073	33,226	64,299	329	8,311		23,243
053 ELECTROCARDIOLOGY								
055 MEDICAL SUPPLIES CHARGED		4,370		4,370	4	466		3,269
056 DRUGS CHARGED TO PATIENTS		2,237		2,237	27	1,271		1,673
061 OUTPAT SERVICE COST CNTRS								
EMERGENCY								
063 OTHER OUTPATIENT SERVICE								
063 02 NEUROPSYCH OFFICE		1,860		1,860	9	209		1,391
063 03 SLEEP LAB		2,225		2,225	43	1,067		1,664
063 04 PHYSICIANS OFFICE		5,270		5,270	5	125		3,942
095 SPEC PURPOSE COST CENTERS								
SUBTOTALS		229,282	33,226	262,508	791	20,700		90,519
101 NONREIMBURS COST CENTERS								
CROSS FOOT ADJUSTMENTS								
102 NEGATIVE COST CENTER								
103 TOTAL		229,282	33,226	262,508	791	20,700		90,519

ALLOCATION OF OLD CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-3039 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART II

COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION		SUBTOTAL
	9	10	11	12	14		25
001 GENERAL SERVICE COST CNTR							
001 01 OLD CAP REL COSTS-BLDG &							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE	5,134						
010 HOUSEKEEPING		3,426					
011 DIETARY		690	42,318				
012 CAFETERIA				6			
014 NURSING ADMINISTRATION		39			2,576		
017 MEDICAL RECORDS & LIBRARY		41				3,066	
025 INPAT ROUTINE SRVC CNTRS							
ADULTS & PEDIATRICS	5,134	1,251	42,318	1	1,545	920	128,709
041 ANCILLARY SRVC COST CNTRS							
041 02 RADIOLOGY-DIAGNOSTIC		8			129		651
044 IMAGING CENTER							
044 LABORATORY					129		159
049 RESPIRATORY THERAPY		11			258	307	1,935
050 PHYSICAL THERAPY		915		5	386	1,532	99,020
053 ELECTROCARDIOLOGY							
055 MEDICAL SUPPLIES CHARGED		129					8,238
056 DRUGS CHARGED TO PATIENTS		66					5,274
061 OUTPAT SERVICE COST CNTRS							
061 EMERGENCY							
063 OTHER OUTPATIENT SERVICE							
063 02 NEUROPSYCH OFFICE		55			129	307	3,960
063 03 SLEEP LAB		66					5,065
063 04 PHYSICIANS OFFICE		155					9,497
095 SPEC PURPOSE COST CENTERS							
SUBTOTALS	5,134	3,426	42,318	6	2,576	3,066	262,508
NONREIMBURS COST CENTERS							
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	5,134	3,426	42,318	6	2,576	3,066	262,508

ALLOCATION OF OLD CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-3039 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART II

COST CENTER DESCRIPTION	POST STEPDOWN ADJUSTMENT	TOTAL
	26	27
001 GENERAL SERVICE COST CNTR		
001 01 OLD CAP REL COSTS-BLDG &		
005 EMPLOYEE BENEFITS		
006 ADMINISTRATIVE & GENERAL		
008 OPERATION OF PLANT		
009 LAUNDRY & LINEN SERVICE		
010 HOUSEKEEPING		
011 DIETARY		
012 CAFETERIA		
014 NURSING ADMINISTRATION		
017 MEDICAL RECORDS & LIBRARY		
025 INPAT ROUTINE SRVC CNTRS		128,709
ADULTS & PEDIATRICS		
ANCILLARY SRVC COST CNTRS		
041 RADIOLOGY-DIAGNOSTIC		651
041 02 IMAGING CENTER		
044 LABORATORY		159
049 RESPIRATORY THERAPY		1,935
050 PHYSICAL THERAPY		99,020
053 ELECTROCARDIOLOGY		
055 MEDICAL SUPPLIES CHARGED		8,238
056 DRUGS CHARGED TO PATIENTS		5,274
061 OUTPAT SERVICE COST CNTRS		
EMERGENCY		
063 OTHER OUTPATIENT SERVICE		
063 02 NEUROPSYCH OFFICE		3,960
063 03 SLEEP LAB		5,065
063 04 PHYSICIANS OFFICE		9,497
095 SPEC PURPOSE COST CENTERS		
SUBTOTALS		262,508
NONREIMBURS COST CENTERS		
101 CROSS FOOT ADJUSTMENTS		
102 NEGATIVE COST CENTER		
103 TOTAL		262,508

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-3039 I FROM 1/ 1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	OLD CAP REL C	OLD CAP REL C	EMPLOYEE BENE	RECONCILIATION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT
	OSTS-BLDG & (SQUARE FEET	OSTS-BLDG & (DIRECT)T ALLOCATIO	(GROSS) SALARIES		(ACCUM. COST	(SQUARE) FEET
	1	1.01	5	6a.00	6	8
GENERAL SERVICE COST						
001 OLD CAP REL COSTS-BLD	57,082					
001 01 OLD CAP REL COSTS-BLD		100				
005 EMPLOYEE BENEFITS	197		7,100,244			
006 ADMINISTRATIVE & GENE	5,123		1,099,385	-2,756,493	10,596,073	
008 OPERATION OF PLANT	21,634		360,947		1,832,514	30,128
009 LAUNDRY & LINEN SERVI	719				43,792	719
010 HOUSEKEEPING	453		71,728		121,176	453
011 DIETARY	5,829		172,895		349,762	5,829
012 CAFETERIA			1,529		2,891	
014 NURSING ADMINISTRATIO	329		95,502		111,186	329
017 MEDICAL RECORDS & LIB	350		215,946		277,948	350
025 INPAT ROUTINE SRVC CN						
ADULTS & PEDIATRICS	10,574		1,092,440		1,624,860	10,574
041 ANCILLARY SRVC COST C						
041 02 RADIOLOGY-DIAGNOSTIC	68		4,190		18,871	68
041 02 IMAGING CENTER						
044 LABORATORY					15,508	
049 RESPIRATORY THERAPY	96		260,000		335,901	96
050 PHYSICAL THERAPY	7,736	100	2,932,550		4,256,128	7,736
053 ELECTROCARDIOLOGY					66	
055 MEDICAL SUPPLIES CHAR	1,088		37,825		238,289	1,088
056 DRUGS CHARGED TO PATI	557		239,580		650,595	557
061 OUTPAT SERVICE COST C						
EMERGENCY						
063 OTHER OUTPATIENT SERV						
063 02 NEUROPSYCH OFFICE	463		79,910		106,771	463
063 03 SLEEP LAB	554		390,250		546,076	554
063 04 PHYSICIANS OFFICE	1,312		45,567		63,739	1,312
095 SPEC PURPOSE COST CEN						
SUBTOTALS	57,082	100	7,100,244	-2,756,493	10,596,073	30,128
101 NONREIMBURS COST CENT						
CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	229,282	33,226	1,067,840		2,756,493	2,309,230
(WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	4.016713		.150395		.260143	
(WRKSHT B, PT I)		332.260000				76.647305
105 COST TO BE ALLOCATED			791		20,700	90,519
(WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER			.000111		.001954	
(WRKSHT B, PT II)						3.004481
107 COST TO BE ALLOCATED						
(WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER						
(WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-3039 I FROM 1/ 1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY
	(POUNDS OF LAUNDRY)	(SQUARE FEET)	(MEALS SERVED)	S(FTE'S)	(DIRECT SING HRS)	NR(TIME SPENT)
	9	10	11	12	14	17
GENERAL SERVICE COST						
001 OLD CAP REL COSTS-BLD						
001 01 OLD CAP REL COSTS-BLD						
005 EMPLOYEE BENEFITS						
006 ADMINISTRATIVE & GENE						
008 OPERATION OF PLANT						
009 LAUNDRY & LINEN SERVI	66,478					
010 HOUSEKEEPING		28,956				
011 DIETARY		5,829	19,674			
012 CAFETERIA				10,426		
014 NURSING ADMINISTRATIO		329		223	100	
017 MEDICAL RECORDS & LIB		350		714		10
INPAT ROUTINE SRVC CN						
025 ADULTS & PEDIATRICS	66,478	10,574	19,674	2,556	60	3
ANCILLARY SRVC COST C						
041 RADIOLOGY-DIAGNOSTIC		68		6	5	
041 02 IMAGING CENTER						
044 LABORATORY					5	
049 RESPIRATORY THERAPY		96		478	10	1
050 PHYSICAL THERAPY		7,736		4,996	15	5
053 ELECTROCARDIOLOGY						
055 MEDICAL SUPPLIES CHAR		1,088		96		
056 DRUGS CHARGED TO PATI		557		298		
OUTPAT SERVICE COST C						
061 EMERGENCY						
063 OTHER OUTPATIENT SERV						
063 02 NEUROPSYCH OFFICE		463		122	5	1
063 03 SLEEP LAB		554		830		
063 04 PHYSICIANS OFFICE		1,312		107		
SPEC PURPOSE COST CEN						
095 SUBTOTALS	66,478	28,956	19,674	10,426	100	10
NONREIMBURS COST CENT						
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	110,293	187,420	925,256	3,643	167,534	379,595
(PER WRKSHT B, PART						
104 UNIT COST MULTIPLIER		6.472579		.349415		37,959.500000
(WRKSHT B, PT I)	1.659090		47.029379		1,675.340000	
105 COST TO BE ALLOCATED	5,134	3,426	42,318	6	2,576	3,066
(PER WRKSHT B, PART						
106 UNIT COST MULTIPLIER		.118317		.000575		306.600000
(WRKSHT B, PT II)	.077229		2.150961		25.760000	
107 COST TO BE ALLOCATED						
(PER WRKSHT B, PART						
108 UNIT COST MULTIPLIER						
(WRKSHT B, PT III)						

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-3039 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	4,177,307		4,177,307		4,177,307
41	ANCILLARY SRVC COST CNTRS					
41	02 RADIOLOGY-DIAGNOSTIC IMAGING CENTER	37,811		37,811		37,811
44	LABORATORY	27,919		27,919		27,919
49	RESPIRATORY THERAPY	486,142		486,142		486,142
50	PHYSICAL THERAPY	6,223,018		6,223,018		6,223,018
53	ELECTROCARDIOLOGY	83		83		83
55	MEDICAL SUPPLIES CHARGED	390,746		390,746		390,746
56	DRUGS CHARGED TO PATIENTS	866,245		866,245		866,245
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY					
63	OTHER OUTPATIENT SERVICE					
63	02 NEUROPSYCH OFFICE	219,412		219,412		219,412
63	03 SLEEP LAB	734,473		734,473	25,871	760,344
63	04 PHYSICIANS OFFICE	189,410		189,410		189,410
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	13,352,566		13,352,566	25,871	13,378,437
102	LESS OBSERVATION BEDS					
103	TOTAL	13,352,566		13,352,566	25,871	13,378,437

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	5,304,329		5,304,329			
41	ANCILLARY SRVC COST CNTRS						
41 02	RADIOLOGY-DIAGNOSTIC IMAGING CENTER	19		19	1990.052632	1990.052632	1990.052632
44	LABORATORY	1,220,861	8,397	1,229,258	.022712	.022712	.022712
49	RESPIRATORY THERAPY	614,778	100,180	714,958	.679959	.679959	.679959
50	PHYSICAL THERAPY	3,655,248	9,269,512	12,924,760	.481480	.481480	.481480
53	ELECTROCARDIOLOGY	85,355		85,355	.000972	.000972	.000972
55	MEDICAL SUPPLIES CHARGED	373,470	12	373,482	1.046224	1.046224	1.046224
56	DRUGS CHARGED TO PATIENTS	974,055	4	974,059	.889315	.889315	.889315
61	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
63	OTHER OUTPATIENT SERVICE						
63 02	NEUROPSYCH OFFICE	141,507	61,382	202,889	1.081439	1.081439	1.081439
63 03	SLEEP LAB	5,758	3,558,331	3,564,089	.206076	.206076	.213335
63 04	PHYSICIANS OFFICE						
101	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	12,375,380	12,997,818	25,373,198			
102	LESS OBSERVATION BEDS						
103	TOTAL	12,375,380	12,997,818	25,373,198			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
I 15-3039 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	4,177,307		4,177,307		4,177,307
41	ANCILLARY SRVC COST CNTRS					
41	02 RADIOLOGY-DIAGNOSTIC	37,811		37,811		37,811
41	02 IMAGING CENTER					
44	LABORATORY	27,919		27,919		27,919
49	RESPIRATORY THERAPY	486,142		486,142		486,142
50	PHYSICAL THERAPY	6,223,018		6,223,018		6,223,018
53	ELECTROCARDIOLOGY	83		83		83
55	MEDICAL SUPPLIES CHARGED	390,746		390,746		390,746
56	DRUGS CHARGED TO PATIENTS	866,245		866,245		866,245
61	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY					
63	OTHER OUTPATIENT SERVICE					
63	02 NEUROPSYCH OFFICE	219,412		219,412		219,412
63	03 SLEEP LAB	734,473		734,473	25,871	760,344
63	04 PHYSICIANS OFFICE	189,410		189,410		189,410
101	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	13,352,566		13,352,566	25,871	13,378,437
102	LESS OBSERVATION BEDS					
103	TOTAL	13,352,566		13,352,566	25,871	13,378,437

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
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	5,304,329		5,304,329			
41	ANCILLARY SRVC COST CNTRS						
41	02 RADIOLOGY-DIAGNOSTIC IMAGING CENTER	19		19	1990.052632	1990.052632	1990.052632
44	LABORATORY	1,220,861	8,397	1,229,258	.022712	.022712	.022712
49	RESPIRATORY THERAPY	614,778	100,180	714,958	.679959	.679959	.679959
50	PHYSICAL THERAPY	3,655,248	9,269,512	12,924,760	.481480	.481480	.481480
53	ELECTROCARDIOLOGY	85,355		85,355	.000972	.000972	.000972
55	MEDICAL SUPPLIES CHARGED	373,470	12	373,482	1.046224	1.046224	1.046224
56	DRUGS CHARGED TO PATIENTS	974,055	4	974,059	.889315	.889315	.889315
61	OUTPAT SERVICE COST CNTRS EMERGENCY						
63	OTHER OUTPATIENT SERVICE						
63	02 NEUROPSYCH OFFICE	141,507	61,382	202,889	1.081439	1.081439	1.081439
63	03 SLEEP LAB	5,758	3,558,331	3,564,089	.206076	.206076	.213335
63	04 PHYSICIANS OFFICE						
101	OTHER REIMBURS COST CNTRS SUBTOTAL	12,375,380	12,997,818	25,373,198			
102	LESS OBSERVATION BEDS						
103	TOTAL	12,375,380	12,997,818	25,373,198			

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
41	ANCILLARY SRVC COST CNTRS						
	RADIOLOGY-DIAGNOSTIC	37,811	651	37,160			37,811
41 02	IMAGING CENTER						
44	LABORATORY	27,919	159	27,760			27,919
49	RESPIRATORY THERAPY	486,142	1,935	484,207			486,142
50	PHYSICAL THERAPY	6,223,018	99,020	6,123,998			6,223,018
53	ELECTROCARDIOLOGY	83		83			83
55	MEDICAL SUPPLIES CHARGED	390,746	8,238	382,508			390,746
56	DRUGS CHARGED TO PATIENTS	866,245	5,274	860,971			866,245
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
63	OTHER OUTPATIENT SERVICE						
63 02	NEUROPSYCH OFFICE	219,412	3,960	215,452			219,412
63 03	SLEEP LAB	734,473	5,065	729,408			734,473
63 04	PHYSICIANS OFFICE	189,410	9,497	179,913			189,410
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	9,175,259	133,799	9,041,460			9,175,259
102	LESS OBSERVATION BEDS						
103	TOTAL	9,175,259	133,799	9,041,460			9,175,259

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
41	ANCILLARY SRVC COST CNTRS			
	RADIOLOGY-DIAGNOSTIC	19	1990.052632	1990.052632
41 02	IMAGING CENTER			
44	LABORATORY	1,229,258	.022712	.022712
49	RESPIRATORY THERAPY	714,958	.679959	.679959
50	PHYSICAL THERAPY	12,924,760	.481480	.481480
53	ELECTROCARDIOLOGY	85,355	.000972	.000972
55	MEDICAL SUPPLIES CHARGED	373,482	1.046224	1.046224
56	DRUGS CHARGED TO PATIENTS	974,059	.889315	.889315
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY			
63	OTHER OUTPATIENT SERVICE			
63 02	NEUROPSYCH OFFICE	202,889	1.081439	1.081439
63 03	SLEEP LAB	3,564,089	.206076	.206076
63 04	PHYSICIANS OFFICE			
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	20,068,869		
102	LESS OBSERVATION BEDS			
103	TOTAL	20,068,869		

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
41	ANCILLARY SRVC COST CNTRS						
41	02 RADIOLOGY-DIAGNOSTIC	37,811	651	37,160	65	2,155	35,591
41	02 IMAGING CENTER						
44	LABORATORY	27,919	159	27,760	16	1,610	26,293
49	RESPIRATORY THERAPY	486,142	1,935	484,207	194	28,084	457,864
50	PHYSICAL THERAPY	6,223,018	99,020	6,123,998	9,902	355,192	5,857,924
53	ELECTROCARDIOLOGY	83		83		5	78
55	MEDICAL SUPPLIES CHARGED	390,746	8,238	382,508	824	22,185	367,737
56	DRUGS CHARGED TO PATIENTS	866,245	5,274	860,971	527	49,936	815,782
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
63	OTHER OUTPATIENT SERVICE						
63	02 NEUROPSYCH OFFICE	219,412	3,960	215,452	396	12,496	206,520
63	03 SLEEP LAB	734,473	5,065	729,408	507	42,306	691,660
63	04 PHYSICIANS OFFICE	189,410	9,497	179,913	950	10,435	178,025
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	9,175,259	133,799	9,041,460	13,381	524,404	8,637,474
102	LESS OBSERVATION BEDS						
103	TOTAL	9,175,259	133,799	9,041,460	13,381	524,404	8,637,474

Health Financial Systems MCRIF32 FOR HRHS SPECIALTY HOSPITAL
 CALCULATION OF OUTPATIENT SERVICE COST TO
 CHARGE RATIOS NET OF REDUCTIONS
 SPECIAL TITLE XIX WORKSHEET

**NOT A CMS WORKSHEET ** (09/2000)
 I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-3039 I FROM 1/ 1/2010 I WORKSHEET C
 I I TO 12/31/2010 I PART II

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
41	ANCILLARY SRVC COST CNTRS			
41	02 RADIOLOGY-DIAGNOSTIC	19	1873.210526	1986.631579
41	02 IMAGING CENTER			
44	LABORATORY	1,229,258	.021389	.022699
49	RESPIRATORY THERAPY	714,958	.640407	.679687
50	PHYSICAL THERAPY	12,924,760	.453233	.480714
53	ELECTROCARDIOLOGY	85,355	.000914	.000972
55	MEDICAL SUPPLIES CHARGED	373,482	.984618	1.044018
56	DRUGS CHARGED TO PATIENTS	974,059	.837508	.888774
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY			
63	OTHER OUTPATIENT SERVICE			
63	02 NEUROPSYCH OFFICE	202,889	1.017896	1.079487
63	03 SLEEP LAB	3,564,089	.194064	.205934
63	04 PHYSICIANS OFFICE			
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	20,068,869		
102	LESS OBSERVATION BEDS			
103	TOTAL	20,068,869		

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	OLD CAPITAL CST/CHRG RATIO 5	CAPITAL COSTS 6
41	ANCILLARY SRVC COST CNTRS						
41	02 RADIOLOGY-DIAGNOSTIC	651		19	19	34.263158	651
44	IMAGING CENTER						
44	LABORATORY	159		1,229,258	1,046,987	.000129	135
49	RESPIRATORY THERAPY	1,935		714,958	527,376	.002706	1,427
50	PHYSICAL THERAPY	99,020		12,924,760	3,100,984	.007661	23,757
53	ELECTROCARDIOLOGY			85,355	72,530		
55	MEDICAL SUPPLIES CHARGED	8,238		373,482	305,420	.022057	6,737
56	DRUGS CHARGED TO PATIENTS	5,274		974,059	831,825	.005414	4,504
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
63	OTHER OUTPATIENT SERVICE						
63	02 NEUROPSYCH OFFICE	3,960		202,889		.019518	
63	03 SLEEP LAB	5,065		3,564,089	5,758	.001421	8
63	04 PHYSICIANS OFFICE	9,497					
	OTHER REIMBURS COST CNTRS						
101	TOTAL	133,799		20,068,869	5,890,899		37,219

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-3039 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART II
 I 15-3039 I

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

TITLE XVIII, PART A HOSPITAL

PPS

WKST A	COST CENTER DESCRIPTION	NEW CAPITAL	
LINE NO.		CST/CHRG RATIO	COSTS
		7	8
	ANCILLARY SRVC COST CNTRS		
41	RADIOLOGY-DIAGNOSTIC		
41 02	IMAGING CENTER		
44	LABORATORY		
49	RESPIRATORY THERAPY		
50	PHYSICAL THERAPY		
53	ELECTROCARDIOLOGY		
55	MEDICAL SUPPLIES CHARGED		
56	DRUGS CHARGED TO PATIENTS		
	OUTPAT SERVICE COST CNTRS		
61	EMERGENCY		
63	OTHER OUTPATIENT SERVICE		
63 02	NEUROPSYCH OFFICE		
63 03	SLEEP LAB		
63 04	PHYSICIANS OFFICE		
	OTHER REIMBURS COST CNTRS		
101	TOTAL		

Health Financial Systems MCRIF32 FOR HRHS SPECIALTY HOSPITAL IN LIEU OF FORM CMS-2552-96(11/1998)

APPORTIONMENT OF INPATIENT ROUTINE I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011

SERVICE OTHER PASS THROUGH COSTS I 15-3039 I FROM 1/ 1/2010 I WORKSHEET D

TITLE XVIII, PART A I I TO 12/31/2010 I PART III

PPS

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					6,558	
101	TOTAL					6,558	

Health Financial Systems MCRIF32 FOR HRHS SPECIALTY HOSPITAL

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

APPORTIONMENT OF INPATIENT ROUTINE
SERVICE OTHER PASS THROUGH COSTS
TITLE XVIII, PART A

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
I 15-3039 I FROM 1/ 1/2010 I WORKSHEET D
I I TO 12/31/2010 I PART III

WKST A	COST CENTER DESCRIPTION	INPATIENT	INPAT PROGRAM
LINE NO.		PROG DAYS	PASS THRU COST
25	ADULTS & PEDIATRICS	7	8
		5,642	
101	TOTAL	5,642	

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST		MED ED SCHOOL	NRS 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
41	ANCILLARY SRVC COST CNTRS							
41	RADIOLOGY-DIAGNOSTIC							
41 02	IMAGING CENTER							
44	LABORATORY							
49	RESPIRATORY THERAPY							
50	PHYSICAL THERAPY							
53	ELECTROCARDIOLOGY							
55	MEDICAL SUPPLIES CHARGED							
56	DRUGS CHARGED TO PATIENTS							
	OUTPAT SERVICE COST CNTRS							
61	EMERGENCY							
63	OTHER OUTPATIENT SERVICE							
63 02	NEUROPSYCH OFFICE							
63 03	SLEEP LAB							
63 04	PHYSICIANS OFFICE							
	OTHER REIMBURS COST CNTRS							
101	TOTAL							

TITLE XVIII, PART A

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
41	ANCILLARY SRVC COST CNTRS							
41	02 RADIOLOGY-DIAGNOSTIC			19				19
44	02 IMAGING CENTER							
44	LABORATORY			1,229,258			1,046,987	
49	RESPIRATORY THERAPY			714,958			527,376	
50	PHYSICAL THERAPY			12,924,760			3,100,984	
53	ELECTROCARDIOLOGY			85,355			72,530	
55	MEDICAL SUPPLIES CHARGED			373,482			305,420	
56	DRUGS CHARGED TO PATIENTS			974,059			831,825	
	OUTPAT SERVICE COST CNTRS							
61	EMERGENCY							
63	OTHER OUTPATIENT SERVICE							
63	02 NEUROPSYCH OFFICE			202,889				
63	03 SLEEP LAB			3,564,089			5,758	
63	04 PHYSICIANS OFFICE							
	OTHER REIMBURS COST CNTRS							
101	TOTAL			20,068,869			5,890,899	

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A	COST CENTER DESCRIPTION	OUTPAT PROG	OUTPAT PROG	OUTPAT PROG	OUTPAT PROG	COL 8.01	COL 8.02
LINE NO.		CHARGES	D,V COL 5.03	D,V COL 5.04	PASS THRU COST	* COL 5	* COL 5
		8	8.01	8.02	9	9.01	9.02
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
41 02	IMAGING CENTER						
44	LABORATORY						
49	RESPIRATORY THERAPY	47,413					
50	PHYSICAL THERAPY	3,454					
53	ELECTROCARDIOLOGY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
63	OTHER OUTPATIENT SERVICE						
63 02	NEUROPSYCH OFFICE						
63 03	SLEEP LAB	1,128,262					
63 04	PHYSICIANS OFFICE						
	OTHER REIMBURS COST CNTRS						
101	TOTAL	1,179,129					

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	1	1.02	2	3	4
(A) ANCILLARY SRVC COST CNTRS					
41 RADIOLOGY-DIAGNOSTIC	1,990.052632	1,990.052632			
41 02 IMAGING CENTER					
44 LABORATORY	.022712	.022712			
49 RESPIRATORY THERAPY	.679959	.679959			
50 PHYSICAL THERAPY	.481480	.481480			
53 ELECTROCARDIOLOGY	.000972	.000972			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.046224	1.046224			
56 DRUGS CHARGED TO PATIENTS	.889315	.889315			
61 OUTPAT SERVICE COST CNTRS					
61 EMERGENCY					
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 02 NEUROPSYCH OFFICE	1.081439	1.081439			
63 03 SLEEP LAB	.206076	.206076			
63 04 PHYSICIANS OFFICE					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	All Other (1)	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr
	5	5.01	5.02	5.03	6
(A) ANCILLARY SRVC COST CNTRS					
41 RADIOLOGY-DIAGNOSTIC					
41 02 IMAGING CENTER					
44 LABORATORY					
49 RESPIRATORY THERAPY		47,413			
50 PHYSICAL THERAPY		3,454			
53 ELECTROCARDIOLOGY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56 DRUGS CHARGED TO PATIENTS					
61 OUTPAT SERVICE COST CNTRS					
61 EMERGENCY					
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 02 NEUROPSYCH OFFICE					
63 03 SLEEP LAB		1,128,262			
63 04 PHYSICIANS OFFICE					
101 SUBTOTAL		1,179,129			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		1,179,129			

TITLE XVIII, PART B		HOSPITAL				
		Outpatient Radiology	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services
Cost Center Description		7	8	9	9.01	9.02
(A)	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC					
41 02	IMAGING CENTER					
44	LABORATORY					
49	RESPIRATORY THERAPY				32,239	
50	PHYSICAL THERAPY				1,663	
53	ELECTROCARDIOLOGY					
55	MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	DRUGS CHARGED TO PATIENTS					
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY					
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 02	NEUROPSYCH OFFICE					
63 03	SLEEP LAB				232,508	
63 04	PHYSICIANS OFFICE					
101	SUBTOTAL				266,410	
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS--					
	PROGRAM ONLY CHARGES					
104	NET CHARGES				266,410	

TITLE XVIII, PART B

HOSPITAL

PPS Services Hospital I/P Hospital I/P
 1/1 to FYE Part B Charges Part B Costs

Cost Center Description	9.03	10	11
(A) ANCILLARY SRVC COST CNTRS			
41 RADIOLOGY-DIAGNOSTIC			
41 02 IMAGING CENTER			
44 LABORATORY			
49 RESPIRATORY THERAPY			
50 PHYSICAL THERAPY			
53 ELECTROCARDIOLOGY			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS			
56 DRUGS CHARGED TO PATIENTS			
OUTPAT SERVICE COST CNTRS			
61 EMERGENCY			
63 OTHER OUTPATIENT SERVICE COST CENTER			
63 02 NEUROPSYCH OFFICE			
63 03 SLEEP LAB			
63 04 PHYSICIANS OFFICE			
101 SUBTOTAL			
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS-			
PROGRAM ONLY CHARGES			
104 NET CHARGES			

TITLE XVIII PART A HOSPITAL PPS

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	6,558
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,558
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,558
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	5,642
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)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	4,177,307
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,177,307

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	5,304,329
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	5,304,329
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.787528
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	808.83
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	4,177,307

TITLE XVIII PART A 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 636.98
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 3,593,841
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 3,593,841

	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)					
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
44 INTENSIVE CARE UNIT					
45 CORONARY CARE UNIT					
46 BURN INTENSIVE CARE UNIT					
47 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					1
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					2,973,836
49 TOTAL PROGRAM INPATIENT COSTS					6,567,677

PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES 110,752
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES 37,219
 52 TOTAL PROGRAM EXCLUDABLE COST 147,971
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS 6,419,706

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

TITLE XVIII PART A HOSPITAL PPS

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

1

- 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

PART IV - COMPUTATION OF OBSERVATION BED COST

- 83 TOTAL OBSERVATION BED DAYS
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 636.98
- 85 OBSERVATION BED COST

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	128,709	4,177,307	.030811		
87 NEW CAPITAL-RELATED COST		4,177,307			
88 NON PHYSICIAN ANESTHETIST		4,177,307			
89 MEDICAL EDUCATION		4,177,307			
89.01 MEDICAL EDUCATION - ALLIED HEA					
89.02 MEDICAL EDUCATION - ALL OTHER					

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

TITLE XVIII, PART A

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		4,551,498	
41	ANCILLARY SRVC COST CNTRS			
41	02 RADIOLOGY-DIAGNOSTIC	1990.052632	19	37,811
44	02 IMAGING CENTER			
44	LABORATORY	.022712	1,046,987	23,779
49	RESPIRATORY THERAPY	.679959	527,376	358,594
50	PHYSICAL THERAPY	.481480	3,100,984	1,493,062
53	ELECTROCARDIOLOGY	.000972	72,530	70
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.046224	305,420	319,538
56	DRUGS CHARGED TO PATIENTS	.889315	831,825	739,754
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY			
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	02 NEUROPSYCH OFFICE	1.081439		
63	03 SLEEP LAB	.213335	5,758	1,228
63	04 PHYSICIANS OFFICE			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		5,890,899	2,973,836
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		5,890,899	

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	OTHER	
			INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		16,402	
41	ANCILLARY SRVC COST CNTRS			
41	02 RADIOLOGY-DIAGNOSTIC IMAGING CENTER	1990.052632		
44	LABORATORY	.022712	3,608	82
49	RESPIRATORY THERAPY	.679959	1,472	1,001
50	PHYSICAL THERAPY	.481480	11,827	5,694
53	ELECTROCARDIOLOGY	.000972	524	1
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.046224	732	766
56	DRUGS CHARGED TO PATIENTS	.889315	4,798	4,267
61	OUTPAT SERVICE COST CNTRS EMERGENCY			
63	02 OTHER OUTPATIENT SERVICE COST CENTER NEUROPSYCH OFFICE	1.081439	601	650
63	03 SLEEP LAB	.206076		
63	04 PHYSICIANS OFFICE OTHER REIMBURS COST CNTRS			
101	TOTAL		23,562	12,461
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		23,562	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/27/2011
I	15-3039	I	FROM 1/ 1/2010	I	WORKSHEET E	
I	COMPONENT NO:	I	TO 12/31/2010	I	PART B	
I	15-3039	I		I		

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	266,410
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	279,665
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)	
	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)	
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	279,665
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	
18.01	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 17.01 (SEE INSTRUCTIONS)	96,792
19	SUBTOTAL (SEE INSTRUCTIONS)	182,873
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	182,873
24	PRIMARY PAYER PAYMENTS	
25	SUBTOTAL	182,873
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	45,102
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	31,571
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	45,102
28	SUBTOTAL	214,444
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	214,444
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	182,872
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	31,572
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 5/27/2011
 I 15-3039 I FROM 1/ 1/2010 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-3039 I 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		6,748,066		182,872
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 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		6,748,066		182,872
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER	.01			
TENTATIVE TO PROVIDER	.02			
TENTATIVE TO PROVIDER	.03			
TENTATIVE TO PROGRAM	.50			
TENTATIVE TO PROGRAM	.51			
TENTATIVE TO PROGRAM	.52			
TENTATIVE TO PROGRAM	.99			
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		5,594		31,572
7 TOTAL MEDICARE PROGRAM LIABILITY		6,742,472		214,444

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

I PROVIDER NO:	I PERIOD:	I PREPARED
I 15-3039	I FROM 1/ 1/2010	I 5/27/2011
I COMPONENT NO:	I TO 12/31/2010	I WORKSHEET E-3
I 15-3039	I	I PART I

PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS AND LTCH PPS AND IPF PPS HOSPITAL

1	INPATIENT HOSPITAL SERVICES (SEE INSTRUCTIONS)	
1.01	HOSPITAL SPECIFIC AMOUNT (SEE INSTRUCTIONS)	
1.02	ENTER FROM THE PS&R, THE IRF PPS PAYMENT	6,775,657
1.03	MEDICARE SSI RATIO (IRF PPS ONLY) (SEE INSTR.)	.0248
1.04	INPATIENT REHABILITATION FACILITY LIP PAYMENTS (SEE INSTRUCTIONS)	122,924
1.05	OUTLIER PAYMENTS	14,351
1.06	TOTAL PPS PAYMENTS (SUM OF LINES 1.01, (1.02, 1.04 FOR COLUMNS 1 & 1.01), 1.05 AND 1.42)	6,912,932
1.07	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)	

INPATIENT PSYCHIATRIC FACILITY (IPF)

1.08	NET FEDERAL IPF PPS PAYMENTS (EXCLUDING OUTLIER, ECT, STOP-LOSS, AND MEDICAL EDUCATION PAYMENTS)	
1.09	NET IPF PPS OUTLIER PAYMENTS	
1.10	NET IPF PPS ECT PAYMENTS	
1.11	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR LATEST COST REPORT FILED PRIOR TO NOVEMBER 15, 2004 (SEE INSTRUCTIONS)	
1.12	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)	
1.13	CURRENT YEARS UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.14	CURRENT YEARS UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.15	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.16	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	
1.17	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{(1 + (LINE 1.15/L.16)) \text{ RAISED TO THE POWER OF } .5150 - 1\}$.	
1.18	MEDICAL EDUCATION ADJUSTMENT (LINE 1.08 MULTIPLIED BY LINE 1.17).	
1.19	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1.08, 1.09, 1.10 AND 1.18)	
1.20	STOP LOSS PAYMENT FLOOR (LINE 1 x 70%)	
1.21	ADJUSTED NET PAYMENT FLOOR (LINE 1.20 x THE APPROPRIATE FEDERAL BLEND PERCENTAGE)	
1.22	STOP LOSS ADJUSTMENT (IF LINE 1.21 IS GREATER THAN LINE 1.19 ENTER THE AMOUNT ON LINE 1.21 LESS LINE 1.19 OTHERWISE ENTER -0-)	
1.23	TOTAL IPF PPS PAYMENTS (SUM OF LINES 1.01, 1.19 AND 1.22)	

INPATIENT REHABILITATION FACILITY (IRF)

1.35	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR COST REPORT PERIODS ENDING ON/OR PRIOR TO NOVEMBER 15, 2004. (SEE INST.)	
1.36	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)	
1.37	CURRENT YEAR'S UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.38	CURRENT YEAR'S UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.39	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.40	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	17.967123
1.41	MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.42	MEDICAL EDUCATION ADJUSTMENT (LINE 1.02 MULTIPLIED BY LINE 1.41).	

2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL (SEE INSTRUCTIONS)	6,912,932
5	PRIMARY PAYER PAYMENTS	
6	SUBTOTAL	6,912,932
7	DEDUCTIBLES	153,936
8	SUBTOTAL	6,758,996
9	COINSURANCE	38,225
10	SUBTOTAL	6,720,771
11	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROF SERV)S	31,002
11.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	21,701
11.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	15,893
12	SUBTOTAL	6,742,472
13	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
13.01	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)	
14	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
15	OTHER ADJUSTMENTS (SPECIFY)	
15.99	OUTLIER RECONCILIATION ADJUSTMENT	
16	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/27/2011
I	15-3039	I	FROM 1/ 1/2010	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 12/31/2010	I	PART I
I	15-3039	I		I	

PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS AND LTCH PPS AND IPF PPS HOSPITAL

17	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	6,742,472
18	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
19	INTERIM PAYMENTS	6,748,066
19.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
20	BALANCE DUE PROVIDER/PROGRAM	-5,594
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	10,000

----- FI ONLY -----

50	ORIGINAL PPS AMOUNT OR 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).	

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	1,194,452			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	1,241,502			
5	OTHER RECEIVABLES	676			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7	INVENTORY	323,050			
8	PREPAID EXPENSES				
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	2,759,680			
FIXED ASSETS					
12	LAND				
12.01					
13	LAND IMPROVEMENTS				
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	785,223			
14.01	LESS ACCUMULATED DEPRECIATION				
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	785,223			
OTHER ASSETS					
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	662,594			
26	TOTAL OTHER ASSETS	662,594			
27	TOTAL ASSETS	4,207,497			

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-3039 I FROM 1/ 1/2010 I
 I I TO 12/31/2010 I WORKSHEET G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	370,212			
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	597,643			
36 TOTAL CURRENT LIABILITIES	967,855			
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				
42 TOTAL LONG-TERM LIABILITIES				
43 TOTAL LIABILITIES	967,855			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	3,239,642			
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	3,239,642			
52 TOTAL LIABILITIES AND FUND BALANCES	4,207,497			

STATEMENT OF CHANGES IN FUND BALANCES

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	FUND BALANCE AT BEGINNING		1,702,475		
	OF PERIOD				
2	NET INCOME (LOSS)		1,537,167		
3	TOTAL		3,239,642		
4	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5	ADDITIONS (CREDIT ADJUSTM				
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL		3,239,642		
12	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13	DEDUCTIONS (DEBIT ADJUSTM				
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF		3,239,642		
	PERIOD PER BALANCE SHEET				

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-3039 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	5,304,329		5,304,329
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	5,304,329		5,304,329
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	5,304,329		5,304,329
17 00 ANCILLARY SERVICES	7,071,051		7,071,051
18 00 OUTPATIENT SERVICES		12,997,818	12,997,818
24 00			
25 00 TOTAL PATIENT REVENUES	12,375,380	12,997,818	25,373,198

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		13,276,514	
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		13,276,514	

STATEMENT OF REVENUES AND EXPENSES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/27/2011
I	15-3039	I	FROM 1/ 1/2010	I	WORKSHEET	G-3
I		I	TO 12/31/2010	I		

DESCRIPTION

1	TOTAL PATIENT REVENUES	25,373,198
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	10,734,227
3	NET PATIENT REVENUES	14,638,971
4	LESS: TOTAL OPERATING EXPENSES	13,276,514
5	NET INCOME FROM SERVICE TO PATIENTS	1,362,457
	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 REVENUE	161,151
24.01	OTHER NONOPERATING REVENUE	13,559
25	TOTAL OTHER INCOME	174,710
26	TOTAL	1,537,167
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	1,537,167