

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

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	I	15-1322	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: 5/25/2011 TIME 11:22

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: PERRY COUNTY HOSPITAL 15-1322 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: 5/25/2011 TIME 11:22

t3XXs.CLgUIw1MDBeBxSK94K7kiJ00
4bh1Q0dQwLaz.D5:sAErtrjfzjg4wm
2dqs0u60g30HmGNj

PI ENCRYPTION INFORMATION
DATE: 5/25/2011 TIME 11:22

2kdEMukOaxLwLxazG0ePbafixcske0
6TNXA0wEqtLI7gbCsPN7nKgBCGSFyn
2G8T5J9sUZ0STG7F

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

[Signature]
CEO
5-27-11

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2	3	4	5	6
1	HOSPITAL	0	-121,671	167,939	0	0
3	SWING BED - SNF	0	-44,638	0	0	0
7	HOSPITAL-BASED HHA	0	0	0	0	0
100	TOTAL	0	-166,309	167,939	0	0

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

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET S-2
 I I TO 12/31/2010 I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: ONE HOSPITAL ROAD P.O. BOX:
 1 CITY: TELL CITY STATE: IN ZIP CODE: 47856- COUNTY: PERRY

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT 0	COMPONENT NAME 1	PROVIDER NO. 2	NPI NUMBER 2.01	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)		
					V	XVIII	XIX
02.00	HOSPITAL	PERRY COUNTY HOSPITAL	15-1322	7/ 1/2004	N	5	6
04.00	SWING BED - SNF	PERRY COUNTY HOSPITAL SWING	15-Z322	7/ 1/2004	N	0	P
09.00	HOSPITAL-BASED HHA	PERRY COUNTY HOSPITAL HHA	15-7177	6/13/1986	N	0	N
12.00	HOSP-BASED HOSPIECE	PERRY COUNTY HOSPITAL HOSPIECE	15-1534	5/17/1995	N	0	N

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

18 TYPE OF CONTROL 1 2
9

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
20 SUBPROVIDER

OTHER INFORMATION

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

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

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

21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 N Y 15999

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

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

21.07 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

21.08 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. N N

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

23 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
I 15-1322 I FROM 1/ 1/2010 I WORKSHEET S-2
I TO 12/31/2010 I

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?
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.
25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N
25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(b)? ENTER "Y" FOR YES OR "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)
25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(c)? ENTER "Y" FOR YES OR "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)
25.07 HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THE COST REPORTING PERIOD? ENTER "Y" FOR YES OR "N" FOR NO IN COLUMN 1.
25.08 IF LINE 25.07 IS YES, ENTER IN COLUMN 1 THE 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. Y 10/ 4/1987
28 IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02
28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS) 1 2 3 4
0 0.0000 0.0000
28.02 ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY 0.00 0

A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR) % Y/N
28.03 STAFFING 0.00%
28.04 RECRUITMENT 0.00%
28.05 RETENTION 0.00%
28.06 TRAINING 0.00%

29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? N
30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) Y
30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70 N
30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS) N
30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).
30.04 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II N
31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). 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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET 5-2
 I I TO 12/31/2010 I

MISCELLANEOUS COST REPORT INFORMATION

- IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2. N
- 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 N N
- 37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N
- 37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE? N N N

TITLE XIX INPATIENT SERVICES

- 38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y
- 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? N
- 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? N
- 38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? N
- 38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? N
- 40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS). Y
- 40.01 NAME: FI/CONTRACTOR NAME FI/CONTRACTOR #
- 40.02 STREET: P.O. BOX:
- 40.03 CITY: STATE: ZIP CODE: -
- 41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y
- 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
- 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
- 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
- 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
- 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N
- 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000
- SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.
- 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?
- 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?
- 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?
- 46 IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

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

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	1	2	3	4	5
47.00 HOSPITAL	N	N	N	N	N
50.00 HHA	N	N			

- 52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N
- 52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV N
- 53 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0
- 53.01 MDH PERIOD: BEGINNING: / / ENDING: / /
- 54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
 - PREMIUMS: 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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX
IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
I 15-1322 I FROM 1/ 1/2010 I WORKSHEET S-2
I I TO 12/31/2010 I

DATE	Y OR N	LIMIT	Y OR N	FEE
0	1	2	3	4
	N	0.00		0
		0.00		0
		0.00		0
		0.00		0

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.

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.

56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.

56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N

58 ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. N

58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). 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

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
					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. Y

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
I 15-1322 I FROM 1/ 1/2010 I WORKSHEET S-3
I I TO 12/31/2010 I PART I

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS		TOTAL TITLE XIX
				TITLE V 3	TITLE XVIII 4	
1 ADULTS & PEDIATRICS	21	7,665	95,904.00		2,691	405
2 HMO						
2 01 HMO - (IRF PPS SUBPROVIDER)						
3 ADULTS & PED-SB SNF					662	
4 ADULTS & PED-SB NF						29
5 TOTAL ADULTS AND PEDS	21	7,665	95,904.00		3,353	434
6 INTENSIVE CARE UNIT	4	1,460	12,096.00		313	
11 NURSERY						111
12 TOTAL	25	9,125	108,000.00		3,666	545
13 RPCH VISITS						
18 HOME HEALTH AGENCY					2,774	
25 TOTAL	25					1,262
26 OBSERVATION BED DAYS						
27 AMBULANCE TRIPS					882	
28 EMPLOYEE DISCOUNT DAYS						
28 01 EMP DISCOUNT DAYS -IRF						
29 LABOR & DELIVERY DAYS						

COMPONENT	I/P DAYS / O/P VISITS / TRIPS		O/P VISITS / TRIPS		O/P VISITS / TRIPS		INTERNS & RES. FTES	
	TITLE XIX OBSERVATION ADMITTED 5.01	BEDS NOT ADMITTED 5.02	TOTAL ALL PATS 6	/ TOTAL OBSERVATION ADMITTED 6.01	BEDS NOT ADMITTED 6.02	TOTAL 7	LESS I&R REPL NON-PHYS ANES 8	
1 ADULTS & PEDIATRICS			3,991					
2 HMO								
2 01 HMO - (IRF PPS SUBPROVIDER)								
3 ADULTS & PED-SB SNF			662					
4 ADULTS & PED-SB NF			29					
5 TOTAL ADULTS AND PEDS			4,682					
6 INTENSIVE CARE UNIT			505					
11 NURSERY			149					
12 TOTAL			5,336					
13 RPCH VISITS								
18 HOME HEALTH AGENCY			4,938					
25 TOTAL								
26 OBSERVATION BED DAYS			500					
27 AMBULANCE TRIPS								
28 EMPLOYEE DISCOUNT DAYS								
28 01 EMP DISCOUNT DAYS -IRF								
29 LABOR & DELIVERY DAYS								

COMPONENT	I & R FTES		FULL TIME EQUIV		DISCHARGES		TOTAL ALL PATIENTS	
	NET 9	EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15	
1 ADULTS & PEDIATRICS				12	13	14	15	
2 HMO					808	217	1,383	
2 01 HMO - (IRF PPS SUBPROVIDER)								
3 ADULTS & PED-SB SNF								
4 ADULTS & PED-SB NF								
5 TOTAL ADULTS AND PEDS								
6 INTENSIVE CARE UNIT								
11 NURSERY								
12 TOTAL		235.83			808	217	1,383	
13 RPCH VISITS								
18 HOME HEALTH AGENCY		4.85						
25 TOTAL		240.68						
26 OBSERVATION BED DAYS								
27 AMBULANCE TRIPS								
28 EMPLOYEE DISCOUNT DAYS								
28 01 EMP DISCOUNT DAYS -IRF								
29 LABOR & DELIVERY DAYS								

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
I 15-1322 I FROM 1/ 1/2010 I WORKSHEET S-4
I HHA NO: I TO 12/31/2010 I
I 15-7177 I
COUNTY: PERRY

HOME HEALTH AGENCY STATISTICAL DATA

HHA 1

	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4
1 HOME HEALTH AIDE HOURS	0	0	0	0
2 UNDUPLICATED CENSUS COUNT		103.00		53.00

TOTAL
5

1 HOME HEALTH AIDE HOURS	0
2 UNDUPLICATED CENSUS COUNT	156.00

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

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK

HHA NO. OF FTE EMPLOYEES (2080 HRS)

STAFF 1	CONTRACT 2	TOTAL 3
------------	---------------	------------

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

HOME HEALTH AGENCY MSA CODES

1	1.01
19 HOW MANY MSAs IN COL. 1 OR CBSAs IN COL. 1.01 DID YOU PROVIDER SERVICES TO DURING THE C/R PERIOD?	1 0
20 LIST THOSE MSA CODE(S) IN COL. 1 & CBSA CODE(S) IN COL. 1.01 SERVICED DURING THIS C/R PERIOD (LINE 20 CONTAINS THE FIRST CODE).	9915

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

	FULL EPISODES		LUPA EPISODES 3	PEP ONLY EPISODES 4
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2		
21 SKILLED NURSING VISITS	912	74	67	7
22 SKILLED NURSING VISIT CHARGES	289,893	23,606	21,343	2,233
23 PHYSICAL THERAPY VISITS	888	8	5	7
24 PHYSICAL THERAPY VISIT CHARGES	204,523	1,848	1,155	1,617
25 OCCUPATIONAL THERAPY VISITS	299	0	1	9
26 OCCUPATIONAL THERAPY VISIT CHARGES	60,318	0	202	1,818
27 SPEECH PATHOLOGY VISITS	34	0	1	0
28 SPEECH PATHOLOGY VISIT CHARGES	7,744	0	231	0
29 MEDICAL SOCIAL SERVICE VISITS	44	0	0	0
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	11,616	0	0	0
31 HOME HEALTH AIDE VISITS	417	0	1	0
32 HOME HEALTH AIDE VISIT CHARGES	69,952	0	168	0
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	2,594	82	75	23
34 OTHER CHARGES	0	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	644,046	25,454	23,099	5,668
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	124	0	29	3
37 TOTAL NUMBER OF OUTLIER EPISODES	0	2	0	0
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	17,440	284	6,571	44

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

HOME HEALTH AGENCY STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET S-4
 I HHA NO: I TO 12/31/2010 I
 I 15-7177 I
 COUNTY: PERRY I

HHA 1

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

	SCIC WITHIN A PEP 5	SCIC ONLY EPISODES 6	TOTAL (COLS. 1-6) 7
21 SKILLED NURSING VISITS	0	0	1,060
22 SKILLED NURSING VISIT CHARGES	0	0	337,075
23 PHYSICAL THERAPY VISITS	0	0	908
24 PHYSICAL THERAPY VISIT CHARGES	0	0	209,143
25 OCCUPATIONAL THERAPY VISITS	0	0	309
26 OCCUPATIONAL THERAPY VISIT CHARGES	0	0	62,338
27 SPEECH PATHOLOGY VISITS	0	0	35
28 SPEECH PATHOLOGY VISIT CHARGES	0	0	7,975
29 MEDICAL SOCIAL SERVICE VISITS	0	0	44
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	11,616
31 HOME HEALTH AIDE VISITS	0	0	418
32 HOME HEALTH AIDE VISIT CHARGES	0	0	70,120
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	0	0	2,774
34 OTHER CHARGES	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	0	0	698,267
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	0	0	156
37 TOTAL NUMBER OF OUTLIER EPISODES	0	0	2
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	0	0	24,339

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
I 15-1322 I FROM 1/ 1/2010 I WORKSHEET S-7
I I TO 12/31/2010 I

GROUP(1) 1	M3PI REVENUE CODE 2	SERVICES PRIOR TO 10/1 RATE 3	10/1 DAYS 3.01	SERVICES ON/AFTER RATE 4	10/1 DAYS 4.01	SRVCS 4/1/01 TO 9/30/01 RATE 4.02	9/30/01 DAYS 4.03
2	RUC						
3	RUB						
3	RUA						
3	.01 RUX						
3	.02 RUL						
4	RVC						
5	RVB						
6	RVA						
6	.01 RVX						
6	.02 RVL						
7	RHC						
8	RHB						
9	RHA						
9	.01 RHX						
9	.02 RHL						
10	RMC						
11	RMB						
12	RMA						
12	.01 RMX						
12	.02 RML						
13	RLB						
14	RLA						
14	.01 R LX						
15	SE3						
16	SE2						
17	SE1						
18	SSC						
19	SSB						
20	SSA						
21	CC2						
22	CC1						
23	CB2						
24	CB1						
25	CA2						
26	CA1						
27	IB2						
28	IB1						
29	IA2						
	IA1						
	BB2						
	BB1						
33	BA2						
34	BA1						
35	PE2						
36	PE1						
37	PD2						
38	PD1						
39	PC2						
40	PC1						
41	PB2						
42	PB1						
43	PA2						
44	PA1						
45	AAA						
45	.01 ES3						
45	.02 ES2						
45	.03 ES1						
45	.04 HE2						
45	.05 HE1						
45	.06 HD2						
45	.07 HD1						
45	.08 HC2						
45	.09 HC1						
45	.10 HB2						
45	.11 HB1						
45	.12 LE2						
45	.13 LE1						
45	.14 LD2						
45	.15 LD1						
45	.16 LC2						
45	.17 LC1						
45	.18 LB2						
45	.19 LB1						
45	.20 CE2						
45	.21 CE1						
45	.22 CD2						
45	.23 CD1						
46	TOTAL						

(1) Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on after October 1st. Enter in column 4.03 the days on 4/1/2001 through 9/30/2001. The sum of the days in column 3.01, 4.01, and 4.03 must agree with the days reported on wkst. S-3, Part I, column 4, line 15. The sum of the days in column 4.06 must agree with the days reported on wkst S-3, Part I column 4, line 3.

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
I 15-1322 I FROM 1/ 1/2010 I WORKSHEET S-7
I I TO 12/31/2010 I

GROUP(1)	M3PI REVENUE CODE	SERVICES PRIOR TO 10/1 RATE	10/1 DAYS	SERVICES ON/AFTER 10/1 RATE	10/1 DAYS	SRVCS 4/1/01 TO 9/30/01 RATE	9/30/01 DAYS
1	2	3	3.01	4	4.01	4.02	4.03

Worksheet S-2 reference data:

Transition Period : 0
Wage Index Factor (before 10/01): 0.0000
Wage Index Factor (after 10/01): 0.0000
SNF Facility Specific Rate : 0.00
Urban/Rural Designation : NOT SPECIFIED
SNF MSA Code : NOT SPECIFIED
SNF CBSA Code : NOT SPECIFIED

GROUP(1)	M3PI REVENUE CODE	HIGH COST(2) RUGs DAYS	SWING BED SNF DAYS	TOTAL
1	2	4.05	4.06	5
1	RUC			
2	RUB			
3	RUA			
3 .01	RUX			
3 .02	RUL			
4	RVC			
5	RVB			
6	RVA			
6 .01	RVX			
6 .02	RVL			
7	RHC			
8	RHB			
9	RHA			
9 .01	RHX			
9 .02	RHL			
10	RMC			
11	RMB			
12	RMA			
12 .01	RMX			
12 .02	RML			
13	RLB			
14	RLA			
14 .01	RLX			
15	SE3			
	SE2			
	SE1			
	SSC			
19	SSB			
20	SSA			
21	CC2			
22	CC1			
23	CB2			
24	CB1			
25	CA2			
26	CA1			
27	IB2			
28	IB1			
29	IA2			
30	IA1			
31	BB2			
32	BB1			
33	BA2			
34	BA1			
35	PE2			
36	PE1			
37	PD2			
38	PD1			
39	PC2			
40	PC1			
41	PB2			
42	PB1			
43	PA2			
44	PA1			
45	AAA			
45 .01	ES3			
45 .02	ES2			
45 .03	ES1			
45 .04	HE2			
45 .05	HE1			
45 .06	HD2			
45 .07	HD1			
45 .08	HC2			
45 .09	HC1			
45 .10	HB2			
45 .11	HB1			
45 .12	LE2			
45 .13	LE1			
45 .14	LD2			
45 .15	LD1			
45 .16	LC2			
45 .17	LC1			
45 .18	LB2			

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
I 15-1322 I FROM 1/ 1/2010 I WORKSHEET S-7
I I TO 12/31/2010 I

GROUP(1)	M3PI REVENUE CODE	HIGH COST(2) RUGs DAYS	SWING BED SNF DAYS	TOTAL
1	2	4.05	4.06	5
.19 LB1				
45 .20 CE2				
45 .21 CE1				
45 .22 CD2				
45 .23 CD1				
46 TOTAL				

- (2) Enter in column 4.05 those days in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs will be incremented by an additional 20% payment.
- (3) Enter in column 4.06 the swing bed days for cost reporting periods beginning on or after 7/1/2002.
- (4) Additional Rugs were published in the "Federal Register", Vol. 74 No. 153 August 11,2009, page 40286. FY 2010 SNF Final Rule These RUGs are effective for services on or after 10/01/2010.

NOTE: The default line code designation has been changed to "AAA".

Worksheet S-2 reference data:
 Transition Period : 0
 Wage Index Factor (before 10/01): 0.0000
 Wage Index Factor (after 10/01) : 0.0000
 SNF Facility Specific Rate : 0.00
 Urban/Rural Designation : NOT SPECIFIED
 SNF MSA Code : NOT SPECIFIED
 SNF CBSA Code : NOT SPECIFIED

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/25/2011
I	15-1322	I	FROM 1/ 1/2010	I	WORKSHEET 5-9
I	HOSPICE NO:	I	TO 12/31/2010	I	
I	15-1534	I		I	

HOSPICE IDENTIFICATION DATA

HOSPICE 1

PART I - ENROLLMENT DAYS

	TITLE XVIII UNDUPLICATED MEDICARE DAYS 1	TITLE XIX UNDUPLICATED MEDICAID DAYS 2	TITLE XVIII UNDUPLICATED SNF DAYS 3	TITLE XIX UNDUPLICATED NF DAYS 4
1 CONTINUOUS HOME CARE				
2 ROUTINE HOME CARE				
3 INPATIENT RESPITE CARE				
4 GENERAL INPATIENT CARE				
5 TOTAL HOSPICE DAYS				

PART I - ENROLLMENT DAYS (CONTINUED)

	OTHER UNDUPLICATED DAYS 5	TOTAL UNDUPLICATED DAYS 6
1 CONTINUOUS HOME CARE		
2 ROUTINE HOME CARE		
3 INPATIENT RESPITE CARE		
4 GENERAL INPATIENT CARE		
5 TOTAL HOSPICE DAYS		

PART II - CENSUS DATA

	TITLE XVIII 1	TITLE XIX 2	TITLE XVIII SNF 3	TITLE XIX NF 4
6 NUMBER OF PATIENTS RECEIVING HOSPICE CARE				
7 TOTAL NUMBER OF UNDUPLICATED CONTINUOUS CARE HOURS BILLABLE TO MEDICARE				
8 AVERAGE LENGTH OF STAY (LINE 5 DIVIDED BY LINE 6)				
9 UNDUPLICATED CENSUS COUNT				

PART II - CENSUS DATA (CONTINUED)

	OTHER 5	TOTAL 6
6 NUMBER OF PATIENTS RECEIVING HOSPICE CARE		
7 TOTAL NUMBER OF UNDUPLICATED CONTINUOUS CARE HOURS BILLABLE TO MEDICARE		
8 AVERAGE LENGTH OF STAY (LINE 5 DIVIDED BY LINE 6)		
9 UNDUPLICATED CENSUS COUNT		

HOSPITAL UNCOMPENSATED CARE DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET S-10
 I I TO 12/31/2010 I
 I I I

DESCRIPTION

UNCOMPENSATED CARE INFORMATION		
1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	
2.01	IS IT AT THE TIME OF ADMISSION?	
2.02	IS IT AT THE TIME OF FIRST BILLING?	
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	
2.04		
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	
4	ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	
5	ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?	
6	ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?	
7	ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?	
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?	
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04	
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	
14	IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02	
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?	
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	
UNCOMPENSATED CARE REVENUES		
17	REVENUE FROM UNCOMPENSATED CARE	122,062
17.01	GROSS MEDICAID REVENUES	1,915,970
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	
20	RESTRICTED GRANTS	
21	NON-RESTRICTED GRANTS	
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	2,038,032
UNCOMPENSATED CARE COST		
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103)	.364780
TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)		
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	
27	TOTAL SCHIP COST, (LINE 24 * LINE 26)	
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	1,915,970

HOSPITAL UNCOMPENSATED CARE DATA

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/25/2011
I	15-1322	I	FROM 1/ 1/2010	I	WORKSHEET	S-10
I		I	TO 12/31/2010	I		
I		I		I		

DESCRIPTION

29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	698,908
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29)	698,908

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/1/2010 I WORKSHEET A
 I I TO 12/31/2010 I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
0300	NEW CAP REL COSTS-BLDG & FIXT		1,224,417	1,224,417	167,770	1,392,187
4 0400	NEW CAP REL COSTS-MVBLE EQUIP				165,224	165,224
5 0500	EMPLOYEE BENEFITS	126,208	3,545,300	3,671,508	-3,184,752	486,756
6 0600	ADMINISTRATIVE & GENERAL	1,664,598	1,854,433	3,519,031	715,604	4,234,635
8 0800	OPERATION OF PLANT	272,456	842,429	1,114,885	267,960	1,382,845
9 0900	LAUNDRY & LINEN SERVICE	855	92,127	92,982	-2	92,980
10 1000	HOUSEKEEPING	201,660	45,494	247,154	164,972	412,126
11 1100	DIETARY	245,595	198,097	443,692	21,271	464,963
12 1200	CAFETERIA				103,083	103,083
14 1400	NURSING ADMINISTRATION	549,254	8,724	557,978	137,545	695,523
17 1700	MEDICAL RECORDS & LIBRARY	167,581	205,021	372,602	21,283	393,885
	INPAT ROUTINE SRVC CNTRS					
25 2500	ADULTS & PEDIATRICS	1,440,686	365,754	1,806,440	450,837	2,257,277
26 2600	INTENSIVE CARE UNIT	274,505	12,354	286,859	56,680	343,539
33 3300	NURSERY	27,584		27,584	-10	27,574
	ANCILLARY SRVC COST CNTRS					
37 3700	OPERATING ROOM	473,718	445,324	919,042	54,697	973,739
39 3900	DELIVERY ROOM & LABOR ROOM	25,380		25,380	-30	25,350
41 4100	RADIOLOGY-DIAGNOSTIC	810,468	962,323	1,772,791	230,333	2,003,124
44 4400	LABORATORY	615,866	676,180	1,292,046	221,471	1,513,517
46 4600	WHOLE BLOOD & PACKED RED BLOOD CELLS	12,136	150,143	162,279	20	162,299
49 4900	RESPIRATORY THERAPY	470,346	324,922	795,268	125,505	920,773
50 5000	PHYSICAL THERAPY	20,477	270,248	290,725	13,305	304,030
51 5100	OCCUPATIONAL THERAPY		52,958	52,958	-28	52,930
52 5200	SPEECH PATHOLOGY		151,082	151,082		151,082
55 5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,949	390,762	445,711	71,780	517,491
55.30 5530	IMPL. DEV. CHARGED TO PATIENT				19,854	19,854
56 5600	DRUGS CHARGED TO PATIENTS	71,777	2,465,876	2,537,653	18,333	2,555,986
	OUTPAT SERVICE COST CNTRS					
60 6000	CLINIC	186,156	62,517	248,673	62,946	311,619
61 6100	EMERGENCY	715,973	1,482,639	2,198,612	331,534	2,530,146
62 6200	OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
65 6500	AMBULANCE SERVICES	507,193	320,760	827,953	55,557	883,510
71 7100	HOME HEALTH AGENCY	243,643	234,993	478,636	71,872	550,508
	SPEC PURPOSE COST CENTERS					
88 8800	INTEREST EXPENSE		144,554	144,554	-144,554	
95 9500	SUBTOTALS	9,179,064	16,529,431	25,708,495	220,060	25,928,555
	NONREIMBURS COST CENTERS					
9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
9800	PHYSICIANS' PRIVATE OFFICES	1,950,031	1,904,672	3,854,703	-202,984	3,651,719
99 9900	NONPAID WORKERS	29,927	164,576	194,503	-17,076	177,427
101	TOTAL	11,159,022	18,598,679	29,757,701	-0-	29,757,701

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSESI PROVIDER NO:
I 15-1322
II PERIOD:
I FROM 1/ 1/2010
I TO 12/31/2010I PREPARED 5/25/2011
I WORKSHEET A
I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
	0300 NEW CAP REL COSTS-BLDG & FIXT	-5,366	1,386,821
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-11,717	153,507
5	0500 EMPLOYEE BENEFITS		486,756
6	0600 ADMINISTRATIVE & GENERAL	-172,288	4,062,347
8	0800 OPERATION OF PLANT	-19,200	1,363,645
9	0900 LAUNDRY & LINEN SERVICE		92,980
10	1000 HOUSEKEEPING		412,126
11	1100 DIETARY	-386	464,577
12	1200 CAFETERIA	-40,432	62,651
14	1400 NURSING ADMINISTRATION		695,523
17	1700 MEDICAL RECORDS & LIBRARY	-5,155	388,730
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS		2,257,277
26	2600 INTENSIVE CARE UNIT		343,539
33	3300 NURSERY		27,574
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM	-337,656	636,083
39	3900 DELIVERY ROOM & LABOR ROOM		25,350
41	4100 RADIOLOGY-DIAGNOSTIC	-127,623	1,875,501
44	4400 LABORATORY		1,513,517
46	4600 WHOLE BLOOD & PACKED RED BLOOD CELLS		162,299
49	4900 RESPIRATORY THERAPY	-207,830	712,943
50	5000 PHYSICAL THERAPY		304,030
51	5100 OCCUPATIONAL THERAPY		52,930
52	5200 SPEECH PATHOLOGY		151,082
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	-22,063	495,428
55.30	5530 IMPL. DEV. CHARGED TO PATIENT		19,854
56	5600 DRUGS CHARGED TO PATIENTS	-1,203	2,554,783
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC		311,619
61	6100 EMERGENCY	-1,199,737	1,330,409
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
	OTHER REIMBURS COST CNTRS		
65	6500 AMBULANCE SERVICES	-3,667	879,843
71	7100 HOME HEALTH AGENCY	-760	549,748
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
95	9500 SUBTOTALS	-2,155,083	23,773,472
	NONREIMBURS COST CENTERS		
9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
9800	PHYSICIANS' PRIVATE OFFICES		3,651,719
99	9900 NONPAID WORKERS		177,427
101	TOTAL	-2,155,083	27,602,618

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I NOT A CMS WORKSHEET
 I I TO 12/31/2010 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
	NEW CAP REL COSTS-BLDG & FIXT	0300	
	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
33	NURSERY	3300	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
39	DELIVERY ROOM & LABOR ROOM	3900	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	4600	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
55.30	IMPL. DEV. CHARGED TO PATIENT	5530	IMPL. DEV. CHARGED TO PATIENT
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
	PHYSICIANS' PRIVATE OFFICES	9800	
	NONPAID WORKERS	9900	
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO: 151322	PERIOD: FROM 1/ 1/2010 TO 12/31/2010	PREPARED 5/25/2011 WORKSHEET A-6
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----- DECREASE -----

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 6	LINE		SALARY 8	OTHER 9	A-7 REF 10
			NO 7				
1 CAFETERIA	B		11		57,059	46,024	
2 INTEREST	C		88			144,554	10
3			98			11,721	
4 LEASE	D		6			4,327	10
5			8			365	
6			17			29,867	
7			25			10,488	
8			37			1,132	
9			41			1,268	
10			49			27,234	
11			50			365	
12			56			64,247	
13			61			485	
14			71			6,673	
15			98			10,212	
16 INSURANCE	E		6			8,949	12
17			65			11,107	12
18 DRUGS	H		6			377	
19			37			44,154	
20			61			9,886	
21			71			351	
22			98			34,243	
23 SUPPLIES	K		25			4,720	
24			26			257	
25			37			45,708	
26			41			586	
27			49			85	
28			50			922	
29			51			28	
30			56			9	
31			60			169	
32			61			2,401	
33			65			2,386	
34			71			3,483	
35			98			30,716	
36							
37 PLANT	L		65			4,108	
38			98			78,271	
39 YELLOW PAGES	M		99			23,047	
40			55			7,857	
41 IMPLANTABLE DEVICES	P						
42			5			3,184,752	
43							
44			9			2	
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RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151322	FROM 1/ 1/2010	5/25/2011
	TO 12/31/2010	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: B
EXPLANATION : CAFETERIA

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	103,083
TOTAL RECLASSIFICATIONS FOR CODE B			103,083

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
DIETARY	11	103,083	103,083

RECLASS CODE: C
EXPLANATION : INTEREST

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	156,275
2.00			0
TOTAL RECLASSIFICATIONS FOR CODE C			156,275

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
INTEREST EXPENSE	88	144,554	144,554
PHYSICIANS' PRIVATE OFFICES	98	11,721	11,721
			156,275

RECLASS CODE: D
EXPLANATION : LEASE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	156,663
2.00			0
3.00			0
4.00			0
5.00			0
6.00			0
7.00			0
8.00			0
9.00			0
10.00			0
11.00			0
12.00			0
TOTAL RECLASSIFICATIONS FOR CODE D			156,663

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	4,327	4,327
OPERATION OF PLANT	8	365	365
MEDICAL RECORDS & LIBRARY	17	29,867	29,867
ADULTS & PEDIATRICS	25	10,488	10,488
OPERATING ROOM	37	1,132	1,132
RADIOLOGY-DIAGNOSTIC	41	1,268	1,268
RESPIRATORY THERAPY	49	27,234	27,234
PHYSICAL THERAPY	50	365	365
DRUGS CHARGED TO PATIENTS	56	64,247	64,247
EMERGENCY	61	485	485
HOME HEALTH AGENCY	71	6,673	6,673
PHYSICIANS' PRIVATE OFFICES	98	10,212	10,212
			156,663

RECLASS CODE: E
EXPLANATION : INSURANCE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	11,107
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	8,949
TOTAL RECLASSIFICATIONS FOR CODE E			20,056

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	8,949	8,949
AMBULANCE SERVICES	65	11,107	11,107
			20,056

RECLASS CODE: H
EXPLANATION : DRUGS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	56	89,011
4.00			0
8.00			0
9.00			0
11.00			0
TOTAL RECLASSIFICATIONS FOR CODE H			89,011

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	377	377
OPERATING ROOM	37	44,154	44,154
EMERGENCY	61	9,886	9,886
HOME HEALTH AGENCY	71	351	351
PHYSICIANS' PRIVATE OFFICES	98	34,243	34,243
			89,011

RECLASS CODE: K
EXPLANATION : SUPPLIES

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	79,473
2.00	IMPL. DEV. CHARGED TO PATIENT	55.30	11,997
3.00			0
4.00			0
5.00			0
6.00			0
7.00			0
8.00			0
9.00			0
10.00			0
11.00			0
12.00			0
13.00			0
TOTAL RECLASSIFICATIONS FOR CODE K			91,470

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADULTS & PEDIATRICS	25	4,720	4,720
INTENSIVE CARE UNIT	26	257	257
OPERATING ROOM	37	45,708	45,708
RADIOLOGY-DIAGNOSTIC	41	586	586
RESPIRATORY THERAPY	49	85	85
PHYSICAL THERAPY	50	922	922
OCCUPATIONAL THERAPY	51	28	28
DRUGS CHARGED TO PATIENTS	56	9	9
CLINIC	60	169	169
EMERGENCY	61	2,401	2,401
AMBULANCE SERVICES	65	2,386	2,386
HOME HEALTH AGENCY	71	3,483	3,483
PHYSICIANS' PRIVATE OFFICES	98	30,716	30,716
			91,470

RECLASSIFICATIONS

PROVIDER NO: 151322	PERIOD: FROM 1/ 1/2010 TO 12/31/2010	PREPARED 5/25/2011 WORKSHEET A-6 NOT A CMS WORKSHEET
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RECLASS CODE: L
EXPLANATION : PLANT

INCREASE			DECREASE		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	OPERATION OF PLANT	82,379	65	AMBULANCE SERVICES	4,108
2.00		0	98	PHYSICIANS' PRIVATE OFFICES	78,271
TOTAL RECLASSIFICATIONS FOR CODE L		82,379			

RECLASS CODE: M
EXPLANATION : YELLOW PAGES

INCREASE			DECREASE		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	23,047	99	NONPAID WORKERS	23,047
TOTAL RECLASSIFICATIONS FOR CODE M		23,047			

RECLASS CODE: P
EXPLANATION : IMPLANTABLE DEVICES

INCREASE			DECREASE		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	IMPL. DEV. CHARGED TO PATIENT	7,857	55	MEDICAL SUPPLIES CHARGED TO PA	7,857
TOTAL RECLASSIFICATIONS FOR CODE P		7,857			

RECLASS CODE: R
EXPLANATION : PAYROLL

INCREASE			DECREASE		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00		0	5	EMPLOYEE BENEFITS	3,184,752
2.00	ADMINISTRATIVE & GENERAL	706,210			0
3.00	OPERATION OF PLANT	185,946			0
4.00		0	9	LAUNDRY & LINEN SERVICE	2
5.00	HOUSEKEEPING	164,972			0
6.00	DIETARY	124,354			0
7.00	NURSING ADMINISTRATION	137,545			0
8.00	MEDICAL RECORDS & LIBRARY	51,150			0
9.00	ADULTS & PEDIATRICS	466,045			0
10.00	INTENSIVE CARE UNIT	56,937			0
11.00		0	33	NURSERY	10
12.00	OPERATING ROOM	145,691			0
13.00		0	39	DELIVERY ROOM & LABOR ROOM	30
14.00	RADIOLOGY-DIAGNOSTIC	232,187			0
15.00	LABORATORY	221,471			0
16.00	WHOLE BLOOD & PACKED RED BLOOD	20			0
17.00	RESPIRATORY THERAPY	152,824			0
18.00	PHYSICAL THERAPY	14,592			0
20.00	MEDICAL SUPPLIES CHARGED TO PA	164			0
21.00		0	56	DRUGS CHARGED TO PATIENTS	6,422
22.00	CLINIC	63,115			0
23.00	EMERGENCY	344,306			0
24.00	AMBULANCE SERVICES	73,158			0
25.00	HOME HEALTH AGENCY	82,379			0
26.00		0	98	PHYSICIANS' PRIVATE OFFICES	37,821
27.00	NONPAID WORKERS	5,971			0
TOTAL RECLASSIFICATIONS FOR CODE R		3,229,037			

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING	PURCHASES	ACQUISITIONS	TOTAL	DISPOSALS	ENDING	FULLY
		BALANCES		DONATION		AND		BALANCE
		1	2	3	4	5	6	7
1	LAND	2,895,311	49,920		49,920		2,945,231	
2	LAND IMPROVEMENTS	1,394,559					1,394,559	
3	BUILDINGS & FIXTURE	10,329,023					10,329,023	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT	6,015,068	1,048,297		1,048,297		7,063,365	
6	MOVABLE EQUIPMENT	8,733,741	486,080		486,080	36,556	9,183,265	
7	SUBTOTAL	29,367,702	1,584,297		1,584,297	36,556	30,915,443	
8	RECONCILING ITEMS							
9	TOTAL	29,367,702	1,584,297		1,584,297	36,556	30,915,443	

III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	GROSS ASSETS 1	COMPUTATION OF RATIOS		RATIO 4	ALLOCATION OF OTHER CAPITAL			TOTAL 8
			LEASES 2	CAPITILIZED GROSS ASSETS FOR RATIO 3		INSURANCE 5	TAXES 6	OTHER CAPITAL RELATED COSTS 7	
3	NEW CAP REL COSTS-BL	21,732,178		21,732,178	.702955				
4	NEW CAP REL COSTS-MV	9,183,265		9,183,265	.297045				
5	TOTAL	30,915,443		30,915,443	1.000000				

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	1,219,051	156,663		11,107		1,386,821	
4	NEW CAP REL COSTS-MV	43,981	100,577		8,949		153,507	
5	TOTAL	1,263,032	257,240		20,056		1,540,328	

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	1,224,417					1,224,417	
4	NEW CAP REL COSTS-MV							
5	TOTAL	1,224,417					1,224,417	

(1) * All lines numbers except line 5 are to be consistent with workshseet A line numbers for capital cost centers.
 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 15-1322
I

I PERIOD: I PREPARED 5/25/2011
I FROM 1/ 1/2010 I WORKSHEET A-8
I TO 12/31/2010 I

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON		WKST. A-7 REF. 5
			WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED	LINE NO	
	1	2	3	4	
1 INVST INCOME-OLD BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
3 INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP	B	-55,698	NEW CAP REL COSTS-MVBLE E	4	10
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	-1,873,604			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1	44,739			
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-40,432	CAFETERIA	12	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHERS					
18 SALE OF MED AND SURG SUPPLIES	B	-22,063	MEDICAL SUPPLIES CHARGED	55	
19 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-1,203	DRUGS CHARGED TO PATIENTS	56	
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-5,155	MEDICAL RECORDS & LIBRARY	17	
21 NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22 VENDING MACHINES					
23 INCOME FROM IMPOSITION OF INTEREST					
24 INTRST EXP ON MEDICARE OVERPAYMENTS					
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28 UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
30 DEPRECIATION-OLD MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34 PHYSICIANS' ASSISTANT					
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		OCCUPATIONAL THERAPY	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
36.31	A-8-4		HOME HEALTH AGENCY	71	
MISC INCOME	B	-33,665	ADMINISTRATIVE & GENERAL	6	
MISC INCOME	B	-3,667	AMBULANCE SERVICES	65	
HHA ADVERTISING	A	-760	HOME HEALTH AGENCY	71	
40 RECRUITING	A	-113,605	ADMINISTRATIVE & GENERAL	6	
41 ADVERTISING	A	-613	ADMINISTRATIVE & GENERAL	6	
42 PHONE	A	-19,200	OPERATION OF PLANT	8	
43 PHONE	A	-5,366	NEW CAP REL COSTS-BLDG &	3	9
44 DIETARY	B	-386	DIETARY	11	
45 AHA	A	-3,644	ADMINISTRATIVE & GENERAL	6	
46 NON ALLOWABLE EXPENSE	A	-20,761	ADMINISTRATIVE & GENERAL	6	
47					
48					
49 OTHER ADJUSTMENTS (SPECIFY)					
50 TOTAL (SUM OF LINES 1 THRU 49)		-2,155,083			

- (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	9
1	4	NEW CAP REL COSTS-MVBLE E	43,981		43,981	
2	41	RADIOLOGY-DIAGNOSTIC	295,105	294,347	758	
3		AMBULANCE DEPRECIATION				
4		MOBILE MRI				
5		TOTALS	339,086	294,347	44,739	

* 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	PERRY COUNTY AMBULANCE		0.00	
2	G	DIAGNOSTIC SHARED SERVICE		0.00	
3				0.00	
4				0.00	
5				0.00	

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

G

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET A-8-2
 I I TO 12/31/2010 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
1	37 SURGERY	140,080	140,080					
2	37 CRNA	197,576	197,576					
3	41 XRAY	128,381	128,381					
4	44 LAB	18,000		18,000				
5	49 CARDIOLOGY	155,830	155,830					
6	49 SLEEP LAB	52,000	52,000					
7	61 ER	1,397,598	1,199,737	197,861				
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	2,089,465	1,873,604	215,861				

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

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET A-8-4
 I I TO 12/31/2010 I PARTS I - VII

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	358
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	283
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	877
7	STANDARD TRAVEL EXPENSE RATE	4.82
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		2384.00	4772.00	
10	AHSEA (SEE INSTRUCTIONS)		64.99	48.75	
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	32.50	32.50	24.38	
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)		69	144	
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)		2,160	7,015	
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	154,936
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	232,635
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	387,571
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	387,571

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	387,571

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	11,635
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	11,635
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	1,726
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	13,361
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	4,484
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	7,020
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	11,504
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	

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

I PROVIDER NO: I 15-1322 I

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

I PREPARED 5/25/2011 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 13,361
 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

36 THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11) 9,198
 37 ASSISTANTS (LINE 6 TIMES COLUMN 3, LINE 11) 21,381
 38 SUBTOTAL (SUM OF LINES 36 AND 37) 30,579
 39 STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF LINES 5 AND 6) 5,591
 40 THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES COLUMN 2, LINE 10)
 41 ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3, LINE 10)
 42 SUBTOTAL (SUM OF LINES 40 AND 41)
 43 OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF COLUMNS 1-3, LINE 13)

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES;
 COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE

44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 38 AND 39 - SEE INSTRUCTIONS) 36,170
 45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 39 AND 42 - SEE INSTRUCTIONS)
 46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 42 AND 43 - SEE INSTRUCTIONS)

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
--	------------	------------	-------	----------	-------

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 387,571
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 13,361
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46) 36,170
 60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)
 61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)
 63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 437,102
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 69,661

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

I PROVIDER NO: I PERIOD:
 I 15-1322 I FROM 1/ 1/2010 I
 I I TO 12/31/2010 I

I PREPARED 5/25/2011
 I WORKSHEET A-8-4
 I PARTS I - VII

PHYSICAL THERAPY

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

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

66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	69,661
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	69,661
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	1.000000
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

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

I PROVIDER NO: I 15-1322

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

I PREPARED 5/25/2011 I WORKSHEET A-8-4 I PARTS I - VII

OCCUPATIONAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	254
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	192
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	249
7	STANDARD TRAVEL EXPENSE RATE	4.82
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		1094.00	962.00	
10	AHSEA (SEE INSTRUCTIONS)		61.61	46.21	
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	30.81	30.81	23.11	
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)		60	21	
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)		2,158	1,670	
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	67,401
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	44,454
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	111,855
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	111,855

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	111,855

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	7,826
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	7,826
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	1,224
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	9,050
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	3,697
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	970
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	4,667
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	

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

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET A-8-4
 I I TO 12/31/2010 I PARTS I - VII

OCCUPATIONAL THERAPY

STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 9,078
 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

36 THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11) 5,916
 37 ASSISTANTS (LINE 6 TIMES COLUMN 3, LINE 11) 5,754
 38 SUBTOTAL (SUM OF LINES 36 AND 37) 11,670
 39 STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF LINES 5 AND 6) 2,126
 40 THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES COLUMN 2, LINE 10)
 41 ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3, LINE 10)
 42 SUBTOTAL (SUM OF LINES 40 AND 41)
 43 OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF COLUMNS 1-3, LINE 13)

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES; COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE

44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 38 AND 39 - SEE INSTRUCTIONS) 13,796
 45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 39 AND 42 - SEE INSTRUCTIONS)
 46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 42 AND 43 - SEE INSTRUCTIONS)

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 111,855
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 9,078
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46) 13,796
 60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)
 61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)
 63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 134,729
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 28,949

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

I PROVIDER NO: I 15-1322 I

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

I PREPARED 5/25/2011 I WORKSHEET A-8-4 I PARTS I - VII

OCCUPATIONAL THERAPY

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

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

66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	28,949
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	28,949
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	1.000000
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

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

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET A-8-4
 I I TO 12/31/2010 I PARTS I - VII

SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	238
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	46
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	4.82
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9		2593.00			
10					
11	29.61	59.22	44.41		
12		29.61	22.21		
12			5		
12.01					
13		291			
13.01					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	153,557
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	153,557
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	153,557

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	153,557

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	7,047
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	7,047
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	1,147
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	8,194
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	296
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	296
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	

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

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET A-8-4
 I I TO 12/31/2010 I PARTS I - VII

SPEECH PATHOLOGY

STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 8,608
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

36 THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11) 1,362
 37 ASSISTANTS (LINE 6 TIMES COLUMN 3, LINE 11)
 38 SUBTOTAL (SUM OF LINES 36 AND 37) 1,362
 39 STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF LINES 5 AND 6) 222
 40 THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES COLUMN 2, LINE 10)
 41 ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3, LINE 10)
 42 SUBTOTAL (SUM OF LINES 40 AND 41)
 43 OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF COLUMNS 1-3, LINE 13)

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES; COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE

44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 38 AND 39 - SEE INSTRUCTIONS) 1,584
 45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 39 AND 42 - SEE INSTRUCTIONS)
 46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 42 AND 43 - SEE INSTRUCTIONS)

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
47 OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)	1	2	3	4	5

48 OVERTIME RATE (SEE INSTRUCTIONS)
 CALCULATION OF LIMIT

49 TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (MULTIPLY LINE 47 TIMES LINE 48)
 50 PERCENTAGE OF OVERTIME HOURS BY CATEGORY (DIVIDE THE HOURS IN EACH COLUMN ON LINE 47 BY THE TOTAL OVERTIME WORKED - COLUMN 5, LINE 47) 100.00 100.00
 51 ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL-TIME EMPLOYEE TIME THE PERCENTAGES ON LINE 50 (SEE INSTRUCTIONS)

DETERMINATION OF OVERTIME ALLOWANCE

52 ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (SEE INSTRUCTIONS)
 53 OVERTIME COST LIMITATION (LINE 51 TIMES LINE 52)
 54 MAXIMUM OVERTIME COST (ENTER THE LESSOR OF LINE 49 OR LINE 53)
 55 PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (MULTIPLY LINE 47 TIMES LINE 52)
 56 OVERTIME ALLOWANCE (LINE 54 MINUS LINE 55 - IF NEGATIVE ENTER ZERO) (ENTER IN COLUMN 5 THE SUM OF COLUMNS 1, 3, AND 4 FOR RESPIRATORY THERAPY AND COLUMNS 1 THROUGH 3 FOR ALL OTHERS.)

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 153,557
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 8,608
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46) 1,584
 60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)
 61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)
 63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 163,749
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 2,760

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

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
I 15-1322 I FROM 1/ 1/2010 I WORKSHEET A-8-4
I I TO 12/31/2010 I PARTS I - VII

SPEECH PATHOLOGY

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

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

66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	2,760
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	2,760
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	1.000000
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 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				
	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEET	ENTERED
	NEW CAP REL COSTS-MVBLE EQUIP	1	SQUARE	FEET	ENTERED
	EMPLOYEE BENEFITS	5	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 5/25/2011
 I 15-1322 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	NEW CAP REL COSTS-BLDG & OSTS	NEW CAP REL COSTS-MVBLE E OSTS	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIVE E & GENERAL	OPERATION OF PLANT
	0	3	4	5	5a.00	6	8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	1,386,821	1,386,821					
005 NEW CAP REL COSTS-MVBLE E	153,507		153,507				
006 EMPLOYEE BENEFITS	486,756	13,636	1,509	501,901			
008 ADMINISTRATIVE & GENERAL	4,062,347	165,830	18,356	75,726	4,322,259	4,322,259	
009 OPERATION OF PLANT	1,363,645	142,800	15,806	12,395	1,534,646	284,924	1,819,570
010 LAUNDRY & LINEN SERVICE	92,980	19,338	2,141	39	114,498	21,258	33,054
011 HOUSEKEEPING	412,126	7,164	793	9,174	429,257	79,696	12,244
012 DIETARY	464,577	92,403	10,228	11,173	578,381	107,383	157,939
014 CAFETERIA	62,651				62,651	11,632	
017 NURSING ADMINISTRATION	695,523	12,568	1,391	24,987	734,469	136,362	21,481
025 MEDICAL RECORDS & LIBRARY	388,730	27,429	3,036	7,624	426,819	79,244	46,882
026 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	2,257,277	271,241	30,024	65,540	2,624,082	487,190	463,612
033 INTENSIVE CARE UNIT	343,539	28,214	3,123	12,488	387,364	71,918	48,225
037 NURSERY	27,574	5,074	562	1,255	34,465	6,399	8,673
037 ANCILLARY SRVC COST CNTRS							
039 OPERATING ROOM	636,083	88,162	9,759	21,550	755,554	140,277	150,689
041 DELIVERY ROOM & LABOR ROO	25,350	10,180	1,127	1,155	37,812	7,020	17,400
044 RADIOLOGY-DIAGNOSTIC	1,875,501	83,575	9,251	36,870	2,005,197	372,287	142,848
046 LABORATORY	1,513,517	16,636	1,841	28,017	1,560,011	289,633	28,435
049 WHOLE BLOOD & PACKED RED	162,299			552	162,851	30,235	
050 RESPIRATORY THERAPY	712,943	35,645	3,946	21,397	773,931	143,689	60,925
051 PHYSICAL THERAPY	304,030	63,875	7,070	932	375,907	69,791	109,177
052 OCCUPATIONAL THERAPY	52,930	2,576	285		55,791	10,358	4,404
055 SPEECH PATHOLOGY	151,082	2,576	285		153,943	28,581	4,404
055 MEDICAL SUPPLIES CHARGED	495,428	3,456	383	2,500	501,767	93,159	5,907
055 30 IMPL. DEV. CHARGED TO PAT	19,854				19,854	3,686	
056 DRUGS CHARGED TO PATIENTS	2,554,783	17,202	1,904	3,265	2,577,154	478,477	29,402
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC	311,619	52,014	5,757	8,469	377,859	70,154	88,904
062 EMERGENCY	1,330,409	52,580	5,820	32,571	1,421,380	263,895	89,871
065 OBSERVATION BEDS (NON-DIS							
071 OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES	879,843	89,921	9,953	23,073	1,002,790	186,179	153,696
071 HOME HEALTH AGENCY	549,748	9,237	1,022	11,084	571,091	106,029	15,788
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	23,773,472	1,313,332	145,372	411,836	23,601,783	3,579,456	1,693,960
NONREIMBURS COST CENTERS							
099 GIFT, FLOWER, COFFEE SHOP		11,688	1,294		12,982	2,410	19,977
101 PHYSICIANS' PRIVATE OFFIC	3,651,719	61,801	6,841	88,704	3,809,065	707,199	105,633
102 NONPAID WORKERS	177,427			1,361	178,788	33,194	
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	27,602,618	1,386,821	153,507	501,901	27,602,618	4,322,259	1,819,570

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	LAUNDRY & LIN HOUSEKEEPING		DIETARY	CAFETERIA	NURSING ADMIN	MEDICAL RECOR	SUBTOTAL
	9	10	11	12	14	17	25
GENERAL SERVICE COST CNTR							
003 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE	168,810						
010 HOUSEKEEPING	10,607	531,804					
011 DIETARY	260	47,339	891,302				
012 CAFETERIA				74,283			
014 NURSING ADMINISTRATION		6,439		5,148	903,899		
017 MEDICAL RECORDS & LIBRARY		14,052		2,999		569,996	
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	70,053	138,959	857,973	21,167	485,729	164,305	5,313,070
026 INTENSIVE CARE UNIT	5,219	14,454	33,329	3,041	69,788		633,338
033 NURSERY	21	2,600		316	7,243		59,717
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	10,811	45,166		3,333	76,474		1,182,304
039 DELIVERY ROOM & LABOR ROO		5,215		297	6,826		74,570
041 RADIOLOGY-DIAGNOSTIC	12,960	42,816		9,348		115,622	2,701,078
044 LABORATORY	450	8,523		8,893		97,366	1,993,311
046 WHOLE BLOOD & PACKED RED				152			193,238
049 RESPIRATORY THERAPY	3,217	18,261		5,712		14,199	1,019,934
050 PHYSICAL THERAPY	2,761	32,724		589		20,285	611,234
051 OCCUPATIONAL THERAPY		1,320				14,199	86,072
052 SPEECH PATHOLOGY		1,320					188,248
055 MEDICAL SUPPLIES CHARGED		1,771		601			603,205
055 30 IMPL. DEV. CHARGED TO PAT							23,540
056 DRUGS CHARGED TO PATIENTS		8,813		1,451			3,095,297
OUTPAT SERVICE COST CNTRS							
060 CLINIC	1,672	26,647		2,847	65,330	28,398	661,811
061 EMERGENCY	50,266	26,937		8,389	192,509	111,565	2,164,812
062 OBSERVATION BEDS (NON-DIS							
OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES	513	46,067				4,057	1,393,302
071 HOME HEALTH AGENCY		4,732					697,640
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	168,810	494,155	891,302	74,283	903,899	569,996	22,695,721
NONREIMBURS COST CENTERS							
GIFT, FLOWER, COFFEE SHOP		5,988					41,357
099 PHYSICIANS' PRIVATE OFFIC		31,661					4,653,558
NONPAID WORKERS							211,982
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	168,810	531,804	891,302	74,283	903,899	569,996	27,602,618

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 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 26	TOTAL 27
GENERAL SERVICE COST CNTR		
003 NEW CAP REL COSTS-BLDG &		
004 NEW CAP REL COSTS-MVBLE E		
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		5,313,070
026 INTENSIVE CARE UNIT		633,338
033 NURSERY		59,717
ANCILLARY SRVC COST CNTRS		
037 OPERATING ROOM		1,182,304
039 DELIVERY ROOM & LABOR ROO		74,570
041 RADIOLOGY-DIAGNOSTIC		2,701,078
044 LABORATORY		1,993,311
046 WHOLE BLOOD & PACKED RED		193,238
049 RESPIRATORY THERAPY		1,019,934
050 PHYSICAL THERAPY		611,234
051 OCCUPATIONAL THERAPY		86,072
052 SPEECH PATHOLOGY		188,248
055 MEDICAL SUPPLIES CHARGED		603,205
055 30 IMPL. DEV. CHARGED TO PAT		23,540
056 DRUGS CHARGED TO PATIENTS		3,095,297
OUTPAT SERVICE COST CNTRS		
060 CLINIC		661,811
061 EMERGENCY		2,164,812
062 OBSERVATION BEDS (NON-DIS		
OTHER REIMBURS COST CNTRS		
065 AMBULANCE SERVICES		1,393,302
071 HOME HEALTH AGENCY		697,640
SPEC PURPOSE COST CENTERS		
095 SUBTOTALS		22,695,721
NONREIMBURS COST CENTERS		
GIFT, FLOWER, COFFEE SHOP		41,357
099 PHYSICIANS' PRIVATE OFFIC		4,653,558
101 NONPAID WORKERS		211,982
102 CROSS FOOT ADJUSTMENT		
103 NEGATIVE COST CENTER		
TOTAL		27,602,618

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	NEW CAP REL COSTS-BLDG & OSTS	NEW CAP REL COSTS-MVBLE & OSTS	SUBTOTAL	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT
	0	3	4	4a	5	6	8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG & OSTS							
005 EMPLOYEE BENEFITS		13,636	1,509	15,145	15,145		
006 ADMINISTRATIVE & GENERAL		165,830	18,356	184,186	2,285	186,471	
008 OPERATION OF PLANT		142,800	15,806	158,606	374	12,293	171,273
009 LAUNDRY & LINEN SERVICE		19,338	2,141	21,479	1	917	3,111
010 HOUSEKEEPING		7,164	793	7,957	277	3,438	1,153
011 DIETARY		92,403	10,228	102,631	337	4,633	14,866
012 CAFETERIA						502	
014 NURSING ADMINISTRATION		12,568	1,391	13,959	754	5,883	2,022
017 MEDICAL RECORDS & LIBRARY		27,429	3,036	30,465	230	3,419	4,413
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS		271,241	30,024	301,265	1,978	21,019	43,639
026 INTENSIVE CARE UNIT		28,214	3,123	31,337	377	3,103	4,539
033 NURSERY		5,074	562	5,636	38	276	816
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		88,162	9,759	97,921	650	6,052	14,184
039 DELIVERY ROOM & LABOR ROO		10,180	1,127	11,307	35	303	1,638
041 RADIOLOGY-DIAGNOSTIC		83,575	9,251	92,826	1,113	16,062	13,446
044 LABORATORY		16,636	1,841	18,477	846	12,496	2,677
046 WHOLE BLOOD & PACKED RED					17	1,304	
049 RESPIRATORY THERAPY		35,645	3,946	39,591	646	6,199	5,735
050 PHYSICAL THERAPY		63,875	7,070	70,945	28	3,011	10,277
051 OCCUPATIONAL THERAPY		2,576	285	2,861		447	415
052 SPEECH PATHOLOGY		2,576	285	2,861		1,233	415
055 MEDICAL SUPPLIES CHARGED		3,456	383	3,839	75	4,019	556
055 30 IMPL. DEV. CHARGED TO PAT						159	
056 DRUGS CHARGED TO PATIENTS		17,202	1,904	19,106	99	20,643	2,768
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC		52,014	5,757	57,771	256	3,027	8,368
061 EMERGENCY		52,580	5,820	58,400	983	11,385	8,459
062 OBSERVATION BEDS (NON-DIS							
062 OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES		89,921	9,953	99,874	696	8,032	14,467
071 HOME HEALTH AGENCY		9,237	1,022	10,259	335	4,574	1,486
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS		1,313,332	145,372	1,458,704	12,430	154,429	159,450
NONREIMBURS COST CENTERS							
099 GIFT, FLOWER, COFFEE SHOP		11,688	1,294	12,982		104	1,880
101 PHYSICIANS' PRIVATE OFFIC		61,801	6,841	68,642	2,674	30,506	9,943
102 NONPAID WORKERS					41	1,432	
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		1,386,821	153,507	1,540,328	15,145	186,471	171,273

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART III

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
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE	25,508						
011 HOUSEKEEPING	1,603	14,428					
012 DIETARY	39	1,284	123,790				
014 CAFETERIA				502			
017 NURSING ADMINISTRATION		175		35	22,828		
025 MEDICAL RECORDS & LIBRARY		381		20		38,928	
026 INPAT ROUTINE SRVC CNTRS							
033 ADULTS & PEDIATRICS	10,585	3,771	119,161	142	12,268	11,222	525,050
037 INTENSIVE CARE UNIT	789	392	4,629	21	1,762		46,949
039 NURSERY	3	71		2	183		7,025
041 ANCILLARY SRVC COST CNTRS							
044 OPERATING ROOM	1,634	1,225		23	1,931		123,620
046 DELIVERY ROOM & LABOR ROO		141		2	172		13,598
049 RADIOLOGY-DIAGNOSTIC	1,958	1,162		63		7,896	134,526
050 LABORATORY	68	231		60		6,650	41,505
051 WHOLE BLOOD & PACKED RED				1			1,322
052 RESPIRATORY THERAPY	486	495		39		970	54,161
055 PHYSICAL THERAPY	417	888		4		1,385	86,955
056 OCCUPATIONAL THERAPY		36				970	4,729
060 SPEECH PATHOLOGY		36					4,545
061 MEDICAL SUPPLIES CHARGED		48		4			8,541
062 30 IMPL. DEV. CHARGED TO PAT							159
065 DRUGS CHARGED TO PATIENTS		239		10			42,865
066 OUTPAT SERVICE COST CNTRS							
067 CLINIC	253	723		19	1,650	1,939	74,006
068 EMERGENCY	7,596	731		57	4,862	7,619	100,092
069 OBSERVATION BEDS (NON-DIS							
070 OTHER REIMBURS COST CNTRS							
071 AMBULANCE SERVICES	77	1,250				277	124,673
075 HOME HEALTH AGENCY		128					16,782
080 SPEC PURPOSE COST CENTERS							
085 SUBTOTALS	25,508	13,407	123,790	502	22,828	38,928	1,411,103
090 NONREIMBURS COST CENTERS							
095 GIFT, FLOWER, COFFEE SHOP		162					15,128
099 PHYSICIANS' PRIVATE OFFIC		859					112,624
101 NONPAID WORKERS							1,473
102 CROSS FOOT ADJUSTMENTS							
103 NEGATIVE COST CENTER							
TOTAL	25,508	14,428	123,790	502	22,828	38,928	1,540,328

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART III

COST CENTER DESCRIPTION	POST STEPDOWN ADJUSTMENT	TOTAL
	26	27
GENERAL SERVICE COST CNTR		
003 NEW CAP REL COSTS-BLDG &		
004 NEW CAP REL COSTS-MVBLE E		
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		525,050
026 INTENSIVE CARE UNIT		46,949
033 NURSERY		7,025
ANCILLARY SRVC COST CNTRS		
037 OPERATING ROOM		123,620
039 DELIVERY ROOM & LABOR ROO		13,598
041 RADIOLOGY-DIAGNOSTIC		134,526
044 LABORATORY		41,505
046 WHOLE BLOOD & PACKED RED		1,322
049 RESPIRATORY THERAPY		54,161
050 PHYSICAL THERAPY		86,955
051 OCCUPATIONAL THERAPY		4,729
052 SPEECH PATHOLOGY		4,545
055 MEDICAL SUPPLIES CHARGED		8,541
055 30 IMPL. DEV. CHARGED TO PAT		159
056 DRUGS CHARGED TO PATIENTS		42,865
OUTPAT SERVICE COST CNTRS		
060 CLINIC		74,006
061 EMERGENCY		100,092
062 OBSERVATION BEDS (NON-DIS		
OTHER REIMBURS COST CNTRS		
065 AMBULANCE SERVICES		124,673
071 HOME HEALTH AGENCY		16,782
SPEC PURPOSE COST CENTERS		
095 SUBTOTALS		1,411,103
NONREIMBURS COST CENTERS		
GIFT, FLOWER, COFFEE SHOP		15,128
PHYSICIANS' PRIVATE OFFIC		112,624
099 NONPAID WORKERS		1,473
101 CROSS FOOT ADJUSTMENTS		
102 NEGATIVE COST CENTER		
103 TOTAL		1,540,328

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	SA RECONCIL-) IATION	ADMINISTRATIV	OPERATION OF
	OSTS-BLDG &	OSTS-MVBLE E	FITS		E & GENERAL	PLANT
	(SQUARE FEET	(SQUARE) FEET	(GROSS)LARIES		(ACCUM. COST	(SQUARE) FEET
	3	4	5	6a.00	6	8
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	88,279					
005 NEW CAP REL COSTS-MVB		88,279				
006 EMPLOYEE BENEFITS	868	868	11,032,814			
008 ADMINISTRATIVE & GENE	10,556	10,556	1,664,598	-4,322,259	23,280,359	
009 OPERATION OF PLANT	9,090	9,090	272,456		1,534,646	67,765
010 LAUNDRY & LINEN SERVI	1,231	1,231	855		114,498	1,231
011 HOUSEKEEPING	456	456	201,660		429,257	456
012 DIETARY	5,882	5,882	245,595		578,381	5,882
014 CAFETERIA					62,651	
017 NURSING ADMINISTRATIO	800	800	549,254		734,469	800
025 MEDICAL RECORDS & LIB	1,746	1,746	167,581		426,819	1,746
026 INPAT ROUTINE SRVC CN						
026 ADULTS & PEDIATRICS	17,266	17,266	1,440,686		2,624,082	17,266
033 INTENSIVE CARE UNIT	1,796	1,796	274,505		387,364	1,796
037 NURSERY	323	323	27,584		34,465	323
039 ANCILLARY SRVC COST C						
041 OPERATING ROOM	5,612	5,612	473,718		755,554	5,612
044 DELIVERY ROOM & LABOR	648	648	25,380		37,812	648
046 RADIOLOGY-DIAGNOSTIC	5,320	5,320	810,468		2,005,197	5,320
049 LABORATORY	1,059	1,059	615,866		1,560,011	1,059
050 WHOLE BLOOD & PACKED			12,136		162,851	
051 RESPIRATORY THERAPY	2,269	2,269	470,346		773,931	2,269
052 PHYSICAL THERAPY	4,066	4,066	20,477		375,907	4,066
055 OCCUPATIONAL THERAPY	164	164			55,791	164
056 SPEECH PATHOLOGY	164	164			153,943	164
060 MEDICAL SUPPLIES CHAR	220	220	54,949		501,767	220
061 30 IMPL. DEV. CHARGED TO					19,854	
062 DRUGS CHARGED TO PATI	1,095	1,095	71,777		2,577,154	1,095
066 OUTPAT SERVICE COST C						
061 CLINIC	3,311	3,311	186,156		377,859	3,311
062 EMERGENCY	3,347	3,347	715,973		1,421,380	3,347
066 OBSERVATION BEDS (NON						
066 OTHER REIMBURS COST C						
066 AMBULANCE SERVICES	5,724	5,724	507,193		1,002,790	5,724
066 HOME HEALTH AGENCY	588	588	243,643		571,091	588
066 SPEC PURPOSE COST CEN						
095 SUBTOTALS	83,601	83,601	9,052,856	-4,322,259	19,279,524	63,087
096 NONREIMBURS COST CENT						
098 GIFT, FLOWER, COFFEE	744	744			12,982	744
099 PHYSICIANS' PRIVATE O	3,934	3,934	1,950,031		3,809,065	3,934
101 NONPAID WORKERS			29,927		178,788	
102 CROSS FOOT ADJUSTMENT						
103 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	1,386,821	153,507	501,901		4,322,259	1,819,570
104 (WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	15.709523		.045492		.185661	
105 (WRKSHT B, PT I)		1.738885				26.851177
105 COST TO BE ALLOCATED						
106 (WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
106 (WRKSHT B, PT II)						
107 COST TO BE ALLOCATED			15,145		186,471	171,273
107 (WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER			.001373		.008010	
108 (WRKSHT B, PT III)						2.527455

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	LAUNDRY & LIN HOUSEKEEPING EN SERVICE		DIETARY	CAFETERIA	NURSING ADMIN	MEDICAL RECOR
	(POUNDS OF LAUNDRY)	(SQUARE FEET)	(MEALS)ERVED	S(FTE'S)	(DIRECT)SING HRS	NR(TIME)SPENT)
	9	10	11	12	14	17
GENERAL SERVICE COST						
003 NEW CAP REL COSTS-BLD						
004 NEW CAP REL COSTS-MVB						
005 EMPLOYEE BENEFITS						
006 ADMINISTRATIVE & GENE						
008 OPERATION OF PLANT						
009 LAUNDRY & LINEN SERVI	24,032					
010 HOUSEKEEPING	1,510	66,078				
011 DIETARY	37	5,882	33,000			
012 CAFETERIA				12,237		
014 NURSING ADMINISTRATIO		800		848	6,489	
017 MEDICAL RECORDS & LIB		1,746		494		281
INPAT ROUTINE SRVC CN						
025 ADULTS & PEDIATRICS	9,973	17,266	31,766	3,487	3,487	81
026 INTENSIVE CARE UNIT	743	1,796	1,234	501	501	
033 NURSERY	3	323		52	52	
ANCILLARY SRVC COST C						
037 OPERATING ROOM	1,539	5,612		549	549	
039 DELIVERY ROOM & LABOR		648		49	49	
041 RADIOLOGY-DIAGNOSTIC	1,845	5,320		1,540		57
044 LABORATORY	64	1,059		1,465		48
046 WHOLE BLOOD & PACKED				25		
049 RESPIRATORY THERAPY	458	2,269		941		7
050 PHYSICAL THERAPY	393	4,066		97		10
051 OCCUPATIONAL THERAPY		164				7
052 SPEECH PATHOLOGY		164				
055 MEDICAL SUPPLIES CHAR		220		99		
30 055 IMPL. DEV. CHARGED TO						
056 DRUGS CHARGED TO PATI		1,095		239		
OUTPAT SERVICE COST C						
060 CLINIC	238	3,311		469	469	14
061 EMERGENCY	7,156	3,347		1,382	1,382	55
062 OBSERVATION BEDS (NON						
OTHER REIMBURS COST C						
AMBULANCE SERVICES	73	5,724				2
HOME HEALTH AGENCY		588				
SPEC PURPOSE COST CEN						
095 SUBTOTALS	24,032	61,400	33,000	12,237	6,489	281
NONREIMBURS COST CENT						
096 GIFT, FLOWER, COFFEE		744				
098 PHYSICIANS' PRIVATE O		3,934				
099 NONPAID WORKERS						
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	168,810	531,804	891,302	74,283	903,899	569,996
(PER WRKSHT B, PART						
104 UNIT COST MULTIPLIER		8.048125		6.070360		2,028.455516
(WRKSHT B, PT I)	7.024384		27.009152		139.297118	
105 COST TO BE ALLOCATED						
(PER WRKSHT B, PART						
106 UNIT COST MULTIPLIER						
(WRKSHT B, PT II)						
107 COST TO BE ALLOCATED	25,508	14,428	123,790	502	22,828	38,928
(PER WRKSHT B, PART						
108 UNIT COST MULTIPLIER		.218348		.041023		138.533808
(WRKSHT B, PT III)	1.061418		3.751212		3.517953	

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 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
	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	5,313,070		5,313,070		5,313,070
26	INTENSIVE CARE UNIT	633,338		633,338		633,338
33	NURSERY	59,717		59,717		59,717
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,182,304		1,182,304		1,182,304
39	DELIVERY ROOM & LABOR ROO	74,570		74,570		74,570
41	RADIOLOGY-DIAGNOSTIC	2,701,078		2,701,078		2,701,078
44	LABORATORY	1,993,311		1,993,311		1,993,311
46	WHOLE BLOOD & PACKED RED	193,238		193,238		193,238
49	RESPIRATORY THERAPY	1,019,934		1,019,934		1,019,934
50	PHYSICAL THERAPY	611,234		611,234		611,234
51	OCCUPATIONAL THERAPY	86,072		86,072		86,072
52	SPEECH PATHOLOGY	188,248		188,248		188,248
55	MEDICAL SUPPLIES CHARGED	603,205		603,205		603,205
55	30 IMPL. DEV. CHARGED TO PAT	23,540		23,540		23,540
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	3,095,297		3,095,297		3,095,297
60	CLINIC	661,811		661,811		661,811
61	EMERGENCY	2,164,812		2,164,812		2,164,812
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	515,160		515,160		515,160
65	AMBULANCE SERVICES	1,393,302		1,393,302		1,393,302
101	SUBTOTAL	22,513,241		22,513,241		22,513,241
102	LESS OBSERVATION BEDS	515,160		515,160		515,160
103	TOTAL	21,998,081		21,998,081		21,998,081

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET C
 I I TO 12/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
	ADULTS & PEDIATRICS	3,175,380		3,175,380			
26	INTENSIVE CARE UNIT	1,198,174		1,198,174			
33	NURSERY	88,953		88,953			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	903,887	3,383,611	4,287,498	.275756	.275756	.275756
39	DELIVERY ROOM & LABOR ROO	134,602	121,632	256,234	.291023	.291023	.291023
41	RADIOLOGY-DIAGNOSTIC	2,070,210	11,819,637	13,889,847	.194464	.194464	.194464
44	LABORATORY	1,799,944	5,582,216	7,382,160	.270017	.270017	.270017
46	WHOLE BLOOD & PACKED RED	186,227	180,267	366,494	.527261	.527261	.527261
49	RESPIRATORY THERAPY	1,564,057	1,861,474	3,425,531	.297745	.297745	.297745
50	PHYSICAL THERAPY	302,138	884,998	1,187,136	.514881	.514881	.514881
51	OCCUPATIONAL THERAPY	99,008	125,809	224,817	.382854	.382854	.382854
52	SPEECH PATHOLOGY	78,863	432,325	511,188	.368256	.368256	.368256
55	MEDICAL SUPPLIES CHARGED	2,149,285	2,714,023	4,863,308	.124032	.124032	.124032
55	30 IMPL. DEV. CHARGED TO PAT		54,846	54,846	.429202	.429202	.429202
56	DRUGS CHARGED TO PATIENTS	5,735,514	7,552,326	13,287,840	.232942	.232942	.232942
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	300	506,657	506,957	1.305458	1.305458	1.305458
61	EMERGENCY	184,784	3,176,152	3,360,936	.644110	.644110	.644110
62	OBSERVATION BEDS (NON-DIS	32,627	404,858	437,485	1.177549	1.177549	1.177549
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		1,800,206	1,800,206	.773968	.773968	.773968
101	SUBTOTAL	19,703,953	40,601,037	60,304,990			
102	LESS OBSERVATION BEDS						
103	TOTAL	19,703,953	40,601,037	60,304,990			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
I 15-1322 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
	INPAT ROUTINE SRVC CNTRS					
	ADULTS & PEDIATRICS	5,313,070		5,313,070		5,313,070
26	INTENSIVE CARE UNIT	633,338		633,338		633,338
33	NURSERY	59,717		59,717		59,717
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,182,304		1,182,304		1,182,304
39	DELIVERY ROOM & LABOR ROO	74,570		74,570		74,570
41	RADIOLOGY-DIAGNOSTIC	2,701,078		2,701,078		2,701,078
44	LABORATORY	1,993,311		1,993,311		1,993,311
46	WHOLE BLOOD & PACKED RED	193,238		193,238		193,238
49	RESPIRATORY THERAPY	1,019,934		1,019,934		1,019,934
50	PHYSICAL THERAPY	611,234		611,234		611,234
51	OCCUPATIONAL THERAPY	86,072		86,072		86,072
52	SPEECH PATHOLOGY	188,248		188,248		188,248
55	MEDICAL SUPPLIES CHARGED	603,205		603,205		603,205
55	30 IMPL. DEV. CHARGED TO PAT	23,540		23,540		23,540
56	DRUGS CHARGED TO PATIENTS	3,095,297		3,095,297		3,095,297
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	661,811		661,811		661,811
61	EMERGENCY	2,164,812		2,164,812		2,164,812
62	OBSERVATION BEDS (NON-DIS	515,160		515,160		515,160
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	1,393,302		1,393,302		1,393,302
101	SUBTOTAL	22,513,241		22,513,241		22,513,241
102	LESS OBSERVATION BEDS	515,160		515,160		515,160
103	TOTAL	21,998,081		21,998,081		21,998,081

COMPUTATION OF RATIO OF COSTS TO CHARGES
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
	ADULTS & PEDIATRICS	3,175,380		3,175,380			
26	INTENSIVE CARE UNIT	1,198,174		1,198,174			
33	NURSERY	88,953		88,953			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	903,887	3,383,611	4,287,498	.275756	.275756	.275756
39	DELIVERY ROOM & LABOR ROO	134,602	121,632	256,234	.291023	.291023	.291023
41	RADIOLOGY-DIAGNOSTIC	2,070,210	11,819,637	13,889,847	.194464	.194464	.194464
44	LABORATORY	1,799,944	5,582,216	7,382,160	.270017	.270017	.270017
46	WHOLE BLOOD & PACKED RED	186,227	180,267	366,494	.527261	.527261	.527261
49	RESPIRATORY THERAPY	1,564,057	1,861,474	3,425,531	.297745	.297745	.297745
50	PHYSICAL THERAPY	302,138	884,998	1,187,136	.514881	.514881	.514881
51	OCCUPATIONAL THERAPY	99,008	125,809	224,817	.382854	.382854	.382854
52	SPEECH PATHOLOGY	78,863	432,325	511,188	.368256	.368256	.368256
55	MEDICAL SUPPLIES CHARGED	2,149,285	2,714,023	4,863,308	.124032	.124032	.124032
55	30 IMPL. DEV. CHARGED TO PAT		54,846	54,846	.429202	.429202	.429202
56	DRUGS CHARGED TO PATIENTS	5,735,514	7,552,326	13,287,840	.232942	.232942	.232942
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	300	506,657	506,957	1.305458	1.305458	1.305458
61	EMERGENCY	184,784	3,176,152	3,360,936	.644110	.644110	.644110
62	OBSERVATION BEDS (NON-DIS	32,627	404,858	437,485	1.177549	1.177549	1.177549
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		1,800,206	1,800,206	.773968	.773968	.773968
101	SUBTOTAL	19,703,953	40,601,037	60,304,990			
102	LESS OBSERVATION BEDS						
103	TOTAL	19,703,953	40,601,037	60,304,990			

WKST A 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
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,182,304	123,620	1,058,684			1,182,304
39	DELIVERY ROOM & LABOR ROO	74,570	13,598	60,972			74,570
41	RADIOLOGY-DIAGNOSTIC	2,701,078	134,526	2,566,552			2,701,078
44	LABORATORY	1,993,311	41,505	1,951,806			1,993,311
46	WHOLE BLOOD & PACKED RED	193,238	1,322	191,916			193,238
49	RESPIRATORY THERAPY	1,019,934	54,161	965,773			1,019,934
50	PHYSICAL THERAPY	611,234	86,955	524,279			611,234
51	OCCUPATIONAL THERAPY	86,072	4,729	81,343			86,072
52	SPEECH PATHOLOGY	188,248	4,545	183,703			188,248
55	MEDICAL SUPPLIES CHARGED	603,205	8,541	594,664			603,205
55	30 IMPL. DEV. CHARGED TO PAT	23,540	159	23,381			23,540
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	3,095,297	42,865	3,052,432			3,095,297
60	CLINIC	661,811	74,006	587,805			661,811
61	EMERGENCY	2,164,812	100,092	2,064,720			2,164,812
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	515,160		515,160			515,160
65	AMBULANCE SERVICES	1,393,302	124,673	1,268,629			1,393,302
101	SUBTOTAL	16,507,116	815,297	15,691,819			16,507,116
102	LESS OBSERVATION BEDS	515,160		515,160			515,160
103	TOTAL	15,991,956	815,297	15,176,659			15,991,956

WKST A NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B RATIO TO CHRGRATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	4,287,498	.275756	.275756
39	DELIVERY ROOM & LABOR ROO	256,234	.291023	.291023
41	RADIOLOGY-DIAGNOSTIC	13,889,847	.194464	.194464
44	LABORATORY	7,382,160	.270017	.270017
46	WHOLE BLOOD & PACKED RED	366,494	.527261	.527261
49	RESPIRATORY THERAPY	3,425,531	.297745	.297745
50	PHYSICAL THERAPY	1,187,136	.514881	.514881
51	OCCUPATIONAL THERAPY	224,817	.382854	.382854
52	SPEECH PATHOLOGY	511,188	.368256	.368256
55	MEDICAL SUPPLIES CHARGED	4,863,308	.124032	.124032
55	30 IMPL. DEV. CHARGED TO PAT	54,846	.429202	.429202
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	13,287,840	.232942	.232942
60	CLINIC	506,957	1.305458	1.305458
61	EMERGENCY	3,360,936	.644110	.644110
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	437,485	1.177549	1.177549
65	AMBULANCE SERVICES	1,800,206	.773968	.773968
101	SUBTOTAL	55,842,483		
102	LESS OBSERVATION BEDS	437,485		
103	TOTAL	55,404,998		

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

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET C
 I I TO 12/31/2010 I PART II

**NOT A CMS WORKSHEET ** (09/2000)

WKST A NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	1,182,304	123,620	1,058,684			1,182,304
39	DELIVERY ROOM & LABOR ROO	74,570	13,598	60,972			74,570
41	RADIOLOGY-DIAGNOSTIC	2,701,078	134,526	2,566,552			2,701,078
44	LABORATORY	1,993,311	41,505	1,951,806			1,993,311
46	WHOLE BLOOD & PACKED RED	193,238	1,322	191,916			193,238
49	RESPIRATORY THERAPY	1,019,934	54,161	965,773			1,019,934
50	PHYSICAL THERAPY	611,234	86,955	524,279			611,234
51	OCCUPATIONAL THERAPY	86,072	4,729	81,343			86,072
52	SPEECH PATHOLOGY	188,248	4,545	183,703			188,248
55	MEDICAL SUPPLIES CHARGED	603,205	8,541	594,664			603,205
55	30 IMPL. DEV. CHARGED TO PAT	23,540	159	23,381			23,540
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	3,095,297	42,865	3,052,432			3,095,297
60	CLINIC	661,811	74,006	587,805			661,811
61	EMERGENCY	2,164,812	100,092	2,064,720			2,164,812
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	515,160		515,160			515,160
65	AMBULANCE SERVICES	1,393,302	124,673	1,268,629			1,393,302
101	SUBTOTAL	16,507,116	815,297	15,691,819			16,507,116
102	LESS OBSERVATION BEDS	515,160		515,160			515,160
103	TOTAL	15,991,956	815,297	15,176,659			15,991,956

WKST A NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	4,287,498	.275756	.275756
39	DELIVERY ROOM & LABOR ROO	256,234	.291023	.291023
41	RADIOLOGY-DIAGNOSTIC	13,889,847	.194464	.194464
44	LABORATORY	7,382,160	.270017	.270017
46	WHOLE BLOOD & PACKED RED	366,494	.527261	.527261
49	RESPIRATORY THERAPY	3,425,531	.297745	.297745
50	PHYSICAL THERAPY	1,187,136	.514881	.514881
51	OCCUPATIONAL THERAPY	224,817	.382854	.382854
52	SPEECH PATHOLOGY	511,188	.368256	.368256
55	MEDICAL SUPPLIES CHARGED	4,863,308	.124032	.124032
55	30 IMPL. DEV. CHARGED TO PAT	54,846	.429202	.429202
56	DRUGS CHARGED TO PATIENTS	13,287,840	.232942	.232942
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	506,957	1.305458	1.305458
61	EMERGENCY	3,360,936	.644110	.644110
62	OBSERVATION BEDS (NON-DIS	437,485	1.177549	1.177549
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	1,800,206	.773968	.773968
101	SUBTOTAL	55,842,483		
102	LESS OBSERVATION BEDS	437,485		
103	TOTAL	55,404,998		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

WKST A NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,188,251	3,353,790			
39	DELIVERY ROOM & LABOR ROO	104,835	216,189			
41	RADIOLOGY-DIAGNOSTIC	2,881,601	12,494,517			
44	LABORATORY	1,973,527	6,224,689			
46	WHOLE BLOOD & PACKED RED	176,466	320,938			
49	RESPIRATORY THERAPY	1,136,659	2,761,125			
50	PHYSICAL THERAPY	895,602	2,063,730			
51	OCCUPATIONAL THERAPY					
52	SPEECH PATHOLOGY					
55	MEDICAL SUPPLIES CHARGED	468,137	4,072,934			
55	30 IMPL. DEV. CHARGED TO PAT					
56	DRUGS CHARGED TO PATIENTS	2,683,508	12,192,463			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	798,178	984,002			
61	EMERGENCY	2,288,491	2,806,799			
62	OBSERVATION BEDS (NON-DIS	508,783	497,554			
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	1,253,893	1,418,930			
101	TOTAL	16,357,931	49,407,660			

COMPUTATION OF OUTPATIENT COST PER VISIT -
RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
I 15-1322 I FROM 1/ 1/2010 I WORKSHEET C
I I TO 12/31/2010 I PART V

WKST A NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT- PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT- PATIENT COSTS 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM	1,188,251	195,302	1,383,553	3,353,790			
39	DELIVERY ROOM & LABOR ROO	104,835		104,835	216,189			
41	RADIOLOGY-DIAGNOSTIC	2,881,601		2,881,601	12,494,517			
44	LABORATORY	1,973,527		1,973,527	6,224,689			
46	WHOLE BLOOD & PACKED RED	176,466		176,466	320,938			
49	RESPIRATORY THERAPY	1,136,659		1,136,659	2,761,125			
50	PHYSICAL THERAPY	895,602		895,602	2,063,730			
51	OCCUPATIONAL THERAPY							
52	SPEECH PATHOLOGY							
55	MEDICAL SUPPLIES CHARGED	468,137		468,137	4,072,934			
55	30 IMPL. DEV. CHARGED TO PAT							
56	DRUGS CHARGED TO PATIENTS	2,683,508		2,683,508	12,192,463			
	OUTPAT SERVICE COST CNTRS							
60	CLINIC	798,178		798,178	984,002			
61	EMERGENCY	2,288,491	774,016	3,062,507	2,806,799			
62	OBSERVATION BEDS (NON-DIS	508,783		508,783	497,554			
	OTHER REIMBURS COST CNTRS							
65	AMBULANCE SERVICES	1,253,893		1,253,893	1,418,930			
101	TOTAL	16,357,931	969,318	17,327,249	49,407,660			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART V
 I 15-1322 I I

TITLE XVIII, PART B

HOSPITAL

	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
Cost Center Description	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.275756		.275756		
39 DELIVERY ROOM & LABOR ROOM	.291023		.291023		
41 RADIOLOGY-DIAGNOSTIC	.194464		.194464		
44 LABORATORY	.270017		.270017		
46 WHOLE BLOOD & PACKED RED BLOOD CELLS	.527261		.527261		
49 RESPIRATORY THERAPY	.297745		.297745		
50 PHYSICAL THERAPY	.514881		.514881		
51 OCCUPATIONAL THERAPY	.382854		.382854		
52 SPEECH PATHOLOGY	.368256		.368256		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.124032		.124032		
55 30 IMPL. DEV. CHARGED TO PATIENT	.429202		.429202		
56 DRUGS CHARGED TO PATIENTS	.232942		.232942		
OUTPAT SERVICE COST CNTRS					
60 CLINIC	1.305458		1.305458		
61 EMERGENCY	.644110		.644110		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.177549		1.177549		
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES	.773968		.773968		
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART V
 I 15-1322 I I

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic 4	All Other (1) 5	Outpatient Ambulatory Surgical Ctr 6	Outpatient Radiology 7	Other Outpatient Diagnostic 8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		952,212			
39 DELIVERY ROOM & LABOR ROOM					
41 RADIOLOGY-DIAGNOSTIC		3,322,069			
44 LABORATORY		2,067,494			
46 WHOLE BLOOD & PACKED RED BLOOD CELLS		148,428			
49 RESPIRATORY THERAPY		779,271			
50 PHYSICAL THERAPY		401,118			
51 OCCUPATIONAL THERAPY		28,096			
52 SPEECH PATHOLOGY		34,451			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		763,275			
30 56 IMPL. DEV. CHARGED TO PATIENTS		45,705			
56 DRUGS CHARGED TO PATIENTS		3,522,967			
OUTPAT SERVICE COST CNTRS					
60 CLINIC		35,722			
61 EMERGENCY		558,704			
62 OBSERVATION BEDS (NON-DISTINCT PART)		230,508			
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES					
101 SUBTOTAL		12,890,020			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		12,890,020			

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART V
 I 15-1322 I I

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
(A) ANCILLARY SRVC COST CNTRS	9	10	11
37 OPERATING ROOM	262,578		
39 DELIVERY ROOM & LABOR ROOM			
41 RADIOLOGY-DIAGNOSTIC	646,023		
44 LABORATORY	558,259		
46 WHOLE BLOOD & PACKED RED BLOOD CELLS	78,260		
49 RESPIRATORY THERAPY	232,024		
50 PHYSICAL THERAPY	206,528		
51 OCCUPATIONAL THERAPY	10,757		
52 SPEECH PATHOLOGY	12,687		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	94,671		
55 30 IMPL. DEV. CHARGED TO PATIENT	19,617		
56 DRUGS CHARGED TO PATIENTS	820,647		
OUTPAT SERVICE COST CNTRS			
60 CLINIC	46,634		
61 EMERGENCY	359,867		
62 OBSERVATION BEDS (NON-DISTINCT PART)	271,434		
OTHER REIMBURS COST CNTRS			
65 AMBULANCE SERVICES			
101 SUBTOTAL	3,619,986		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104 NET CHARGES	3,619,986		

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

I PROVIDER NO:	I PERIOD:	I PREPARED 5/25/2011
I 15-1322	I FROM 1/ 1/2010	I WORKSHEET D
I COMPONENT NO:	I TO 12/31/2010	I PART VI
I 15-1322	I	I

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1
2	PROGRAM VACCINE CHARGES	.232942
3	PROGRAM COSTS	8,391
		1,955

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D
 I I TO 12/31/2010 I PART I

TITLE XIX

PPS

A NO.	COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
		CAPITAL REL COST (B, II) 1	SWING BED ADJUSTMENT 2	REDUCED CAP RELATED COST 3	CAPITAL REL COST (B, III) 4	SWING BED ADJUSTMENT 5	REDUCED CAP RELATED COST 6
25	INPAT ROUTINE SRVC CNTRS						
26	ADULTS & PEDIATRICS				525,050	67,782	457,268
33	INTENSIVE CARE UNIT				46,949		46,949
101	NURSERY				7,025		7,025
	TOTAL				579,024		511,242

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D
 I I TO 12/31/2010 I PART I

TITLE XIX

PPS

WKST A NO.	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	INPAT PROGRAM OLD CAP CST 10	NEW CAPITAL PER DIEM 11	INPAT PROGRAM NEW CAP CST 12
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	4,491	405			101.82	41,237
26	INTENSIVE CARE UNIT	505				92.97	
33	NURSERY	149	111			47.15	5,234
101	TOTAL	5,145	516				46,471

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART II
 I 15-1322 I I

TITLE XIX

HOSPITAL

PPS

WKST A 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
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM		123,620	4,287,498	227,679		
39	DELIVERY ROOM & LABOR ROO		13,598	256,234	90,783		
41	RADIOLOGY-DIAGNOSTIC		134,526	13,889,847	165,960		
44	LABORATORY		41,505	7,382,160	172,142		
46	WHOLE BLOOD & PACKED RED		1,322	366,494	15,935		
49	RESPIRATORY THERAPY		54,161	3,425,531	196,394		
50	PHYSICAL THERAPY		86,955	1,187,136	9,049		
51	OCCUPATIONAL THERAPY		4,729	224,817	2,662		
52	SPEECH PATHOLOGY		4,545	511,188	5,984		
55	MEDICAL SUPPLIES CHARGED		8,541	4,863,308	177,641		
55 30	IMPL. DEV. CHARGED TO PAT		159	54,846			
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS		42,865	13,287,840	512,467		
60	CLINIC		74,006	506,957	168		
61	EMERGENCY		100,092	3,360,936	42,658		
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS			437,485	14,643		
65	AMBULANCE SERVICES						
101	TOTAL		690,624	54,042,277	1,634,165		

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART II
 I 15-1322 I I

TITLE XIX HOSPITAL

WKST A NO.	COST CENTER DESCRIPTION	NEW CAPITAL	
		CST/CHRG 7	RATIO 8
	ANCILLARY SRVC COST CNTRS		
37	OPERATING ROOM	.028833	6,565
39	DELIVERY ROOM & LABOR ROO	.053069	4,818
41	RADIOLOGY-DIAGNOSTIC	.009685	1,607
44	LABORATORY	.005622	968
46	WHOLE BLOOD & PACKED RED	.003607	57
49	RESPIRATORY THERAPY	.015811	3,105
50	PHYSICAL THERAPY	.073248	663
51	OCCUPATIONAL THERAPY	.021035	56
52	SPEECH PATHOLOGY	.008891	53
55	MEDICAL SUPPLIES CHARGED	.001756	312
55 30	IMPL. DEV. CHARGED TO PAT	.002899	
56	DRUGS CHARGED TO PATIENTS	.003226	1,653
	OUTPAT SERVICE COST CNTRS		
60	CLINIC	.145981	25
61	EMERGENCY	.029781	1,270
62	OBSERVATION BEDS (NON-DIS		
	OTHER REIMBURS COST CNTRS		
65	AMBULANCE SERVICES		
101	TOTAL		21,152

PPS

APPORTIONMENT OF INPATIENT ROUTINE
 SERVICE OTHER PASS THROUGH COSTS
 TITLE XIX

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D
 I I TO 12/31/2010 I PART III
 PPS

WKST A 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
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS					4,491	
26	INTENSIVE CARE UNIT					505	
33	NURSERY					149	
101	TOTAL					5,145	

APPORTIONMENT OF INPATIENT ROUTINE
SERVICE OTHER PASS THROUGH COSTS
TITLE XIX

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D
I I TO 12/31/2010 I PART III

WKST A NO.	COST CENTER DESCRIPTION	INPATIENT PROG DAYS	INPAT PROGRAM PASS THRU COST
		7	8
	ADULTS & PEDIATRICS		405
26	INTENSIVE CARE UNIT		
33	NURSERY		111
101	TOTAL		516

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART IV
 I 15-1322 I I

TITLE XIX HOSPITAL

WKST A NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST	HOSPITAL	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
37	ANCILLARY SRVC COST CNTRS							
39	OPERATING ROOM							
41	DELIVERY ROOM & LABOR ROO							
44	RADIOLOGY-DIAGNOSTIC							
46	LABORATORY							
49	WHOLE BLOOD & PACKED RED							
50	RESPIRATORY THERAPY							
51	PHYSICAL THERAPY							
52	OCCUPATIONAL THERAPY							
55	SPEECH PATHOLOGY							
55	MEDICAL SUPPLIES CHARGED							
56	30 IMPL. DEV. CHARGED TO PAT							
60	DRUGS CHARGED TO PATIENTS							
61	OUTPAT SERVICE COST CNTRS							
62	CLINIC							
65	EMERGENCY							
101	62 OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS AMBULANCE SERVICES TOTAL							

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART IV
 I 15-1322 I I

TITLE XIX

HOSPITAL

PPS

WKST A 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 CST 5.01	RATIO OF TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS								
37	OPERATING ROOM			4,287,498				227,679	
39	DELIVERY ROOM & LABOR ROO			256,234				90,783	
41	RADIOLOGY-DIAGNOSTIC			13,889,847				165,960	
44	LABORATORY			7,382,160				172,142	
46	WHOLE BLOOD & PACKED RED			366,494				15,935	
49	RESPIRATORY THERAPY			3,425,531				196,394	
50	PHYSICAL THERAPY			1,187,136				9,049	
51	OCCUPATIONAL THERAPY			224,817				2,662	
52	SPEECH PATHOLOGY			511,188				5,984	
55	MEDICAL SUPPLIES CHARGED			4,863,308				177,641	
55	30 IMPL. DEV. CHARGED TO PAT			54,846					
56	DRUGS CHARGED TO PATIENTS			13,287,840				512,467	
	OUTPAT SERVICE COST CNTRS								
60	CLINIC			506,957				168	
61	EMERGENCY			3,360,936				42,658	
62	OBSERVATION BEDS (NON-DIS			437,485				14,643	
	OTHER REIMBURS COST CNTRS								
65	AMBULANCE SERVICES								
101	TOTAL			54,042,277				1,634,165	

TITLE XIX

HOSPITAL

PPS

WKST A NO.	COST CENTER DESCRIPTION	OUTPAT PROG	OUTPAT PROG	OUTPAT PROG	OUTPAT PROG	COL 8.01	COL 8.02
		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						
37	OPERATING ROOM	451,566					
39	DELIVERY ROOM & LABOR ROO	84,760					
41	RADIOLOGY-DIAGNOSTIC	1,641,886					
44	LABORATORY	836,417					
46	WHOLE BLOOD & PACKED RED	9,370					
49	RESPIRATORY THERAPY	248,658					
50	PHYSICAL THERAPY	111,460					
51	OCCUPATIONAL THERAPY	21,678					
52	SPEECH PATHOLOGY	192,109					
55	MEDICAL SUPPLIES CHARGED	481,082					
55 30	IMPL. DEV. CHARGED TO PAT						
56	DRUGS CHARGED TO PATIENTS	1,068,080					
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	42,350					
61	EMERGENCY	654,309					
62	OBSERVATION BEDS (NON-DIS	59,805					
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	129,668					
101	TOTAL	6,033,198					

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART V
 I 15-1322 I I

TITLE XIX - O/P

HOSPITAL

	Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1)
Cost Center Description	1	2	3	4	5
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.275756				451,566
39 DELIVERY ROOM & LABOR ROOM	.291023				84,760
41 RADIOLOGY-DIAGNOSTIC	.194464				1,641,886
44 LABORATORY	.270017				836,417
46 WHOLE BLOOD & PACKED RED BLOOD CELLS	.527261				9,370
49 RESPIRATORY THERAPY	.297745				248,658
50 PHYSICAL THERAPY	.514881				111,460
51 OCCUPATIONAL THERAPY	.382854				21,678
52 SPEECH PATHOLOGY	.368256				192,109
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.124032				481,082
30 IMPL. DEV. CHARGED TO PATIENT	.429202				
56 DRUGS CHARGED TO PATIENTS	.232942				1,068,080
OUTPAT SERVICE COST CNTRS					
60 CLINIC	1.305458				42,350
61 EMERGENCY	.644110				654,309
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.177549				59,805
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES	.773968				129,668
101 SUBTOTAL					6,033,198
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES					6,033,198

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART V
 I 15-1322 I I

TITLE XIX - O/P

HOSPITAL

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

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART V
 I 15-1322 I I

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
(A) ANCILLARY SRVC COST CNTRS	8	9	9.01	9.02	9.03
37 OPERATING ROOM		124,522			
39 DELIVERY ROOM & LABOR ROOM		24,667			
41 RADIOLOGY-DIAGNOSTIC		319,288			
44 LABORATORY		225,847			
46 WHOLE BLOOD & PACKED RED BLOOD CELLS		4,940			
49 RESPIRATORY THERAPY		74,037			
50 PHYSICAL THERAPY		57,389			
51 OCCUPATIONAL THERAPY		8,300			
52 SPEECH PATHOLOGY		70,745			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		59,670			
30 56 IMPL. DEV. CHARGED TO PATIENT					
56 DRUGS CHARGED TO PATIENTS		248,801			
OUTPAT SERVICE COST CNTRS					
60 CLINIC		55,286			
61 EMERGENCY		421,447			
62 OBSERVATION BEDS (NON-DISTINCT PART)		70,423			
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES		100,359			
101 SUBTOTAL		1,865,721			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		1,865,721			

(A) WORKSHEET A LINE NUMBERS

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

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/25/2011
I	15-1322	I	FROM 1/ 1/2010	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 12/31/2010	I	PART I
I	15-1322	I		I	

COMPUTATION OF INPATIENT OPERATING COST

TITLE XVIII PART A

HOSPITAL

OTHER

I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	5,182
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,491
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,491
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	662
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	29
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)	2,691
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	662
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	
	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	132.00
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	132.00
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	5,313,070
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	3,828
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	685,900
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,627,170

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,264,333
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,264,333
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.417493
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	726.86
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	4,627,170

TITLE XVIII PART A HOSPITAL OTHER
 II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM					1,030.32
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					2,772,591
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					2,772,591

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY) INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS				
43	633,338	505	1,254.13	313	392,543
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				
49	TOTAL PROGRAM INPATIENT COSTS				

1
 2,004,480
 5,169,614

PASS THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	682,072
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	682,072
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	

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2010 I PART III
 I 15-1322 I I

COMPUTATION OF INPATIENT OPERATING COST

TITLE XVIII PART A HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BED DAYS 500
 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 1,030.32
 85 OBSERVATION BED COST 515,160

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

COMPUTATION OF INPATIENT OPERATING COST

TITLE XIX - I/P HOSPITAL PPS

1 I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	5,182
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,491
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,491
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	662
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	29
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)	405
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	29
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)	149
16	NURSERY DAYS (TITLE V OR XIX ONLY)	111

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	132.00
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	132.00
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	5,313,070
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	3,828
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	685,900
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,627,170

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,264,333
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,264,333
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.417493
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	726.86
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	4,627,170

COMPUTATION OF INPATIENT OPERATING COST

TITLE XIX - I/P

HOSPITAL

PPS

II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM					1,030.32
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					417,280
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					417,280

	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST	
	1	2	3	4	5	
42	NURSERY (TITLE V & XIX ONLY)	59,717	149	400.79	111	44,488
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT	633,338	505	1,254.13		
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					
48	PROGRAM INPATIENT ANCILLARY SERVICE COST					1
49	TOTAL PROGRAM INPATIENT COSTS					429,063
						890,831

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES					46,471
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES					21,152
52	TOTAL PROGRAM EXCLUDABLE COST					67,623
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS					823,208

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	3,828
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	3,828

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2010 I PART III
 I 15-1322 I I

COMPUTATION OF INPATIENT OPERATING COST

TITLE XIX - I/P 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 500
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 1,030.32
- 85 OBSERVATION BED COST 515,160

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86 OLD CAPITAL-RELATED COST		4,627,170		515,160	
87 NEW CAPITAL-RELATED COST	525,050	4,627,170	.113471	515,160	58,456
88 NON PHYSICIAN ANESTHETIST		4,627,170		515,160	
MEDICAL EDUCATION		4,627,170		515,160	
01 MEDICAL EDUCATION - ALLIED HEA					
02 MEDICAL EDUCATION - ALL OTHER					

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-1322 I

TITLE XVIII, PART A HOSPITAL

WKST A NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES	OTHER	
			INPATIENT CHARGES	INPATIENT COST
		1	2	3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		2,081,661	
26	INTENSIVE CARE UNIT		505,808	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.275756	147,179	40,585
39	DELIVERY ROOM & LABOR ROOM	.291023		
41	RADIOLOGY-DIAGNOSTIC	.194464	905,078	176,005
44	LABORATORY	.270017	1,221,854	329,921
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	.527261	113,541	59,866
49	RESPIRATORY THERAPY	.297745	1,213,508	361,316
50	PHYSICAL THERAPY	.514881	136,434	70,247
51	OCCUPATIONAL THERAPY	.382854	30,120	11,532
52	SPEECH PATHOLOGY	.368256	51,135	18,831
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.124032	1,174,585	145,686
55	30 IMPL. DEV. CHARGED TO PATIENT	.429202		
56	DRUGS CHARGED TO PATIENTS	.232942	3,390,781	789,855
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	1.305458		
61	EMERGENCY	.644110	987	636
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.177549		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		8,385,202	2,004,480
102	LESS PBP CLINIC LABORATORY SERVICES -			
	PROGRAM ONLY CHARGES			
103	NET CHARGES		8,385,202	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-2322 I

TITLE XVIII, PART A SWING BED SNF

OTHER

WKST A NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.275756		
39	DELIVERY ROOM & LABOR ROOM	.291023		
41	RADIOLOGY-DIAGNOSTIC	.194464	28,372	5,517
44	LABORATORY	.270017	45,935	12,403
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	.527261		
49	RESPIRATORY THERAPY	.297745	74,576	22,205
50	PHYSICAL THERAPY	.514881	129,814	66,839
51	OCCUPATIONAL THERAPY	.382854	57,568	22,040
52	SPEECH PATHOLOGY	.368256	16,031	5,904
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.124032	125,269	15,537
55	30 IMPL. DEV. CHARGED TO PATIENT	.429202		
56	DRUGS CHARGED TO PATIENTS	.232942	268,484	62,541
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	1.305458		
61	EMERGENCY	.644110		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.177549		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		746,049	212,986
102	LESS PBP CLINIC LABORATORY SERVICES -			
	PROGRAM ONLY CHARGES			
103	NET CHARGES		746,049	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-1322 I

TITLE XIX HOSPITAL PPS

WKST A NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		283,935	
26	INTENSIVE CARE UNIT		76,194	
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.275756	227,679	62,784
39	DELIVERY ROOM & LABOR ROOM	.291023	90,783	26,420
41	RADIOLOGY-DIAGNOSTIC	.194464	165,960	32,273
44	LABORATORY	.270017	172,142	46,481
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	.527261	15,935	8,402
49	RESPIRATORY THERAPY	.297745	196,394	58,475
50	PHYSICAL THERAPY	.514881	9,049	4,659
51	OCCUPATIONAL THERAPY	.382854	2,662	1,019
52	SPEECH PATHOLOGY	.368256	5,984	2,204
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.124032	177,641	22,033
55	30 IMPL. DEV. CHARGED TO PATIENT	.429202		
56	DRUGS CHARGED TO PATIENTS	.232942	512,467	119,375
	OUTPAT SERVICE COST CNTRS CLINIC	1.305458	168	219
61	EMERGENCY	.644110	42,658	27,476
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.177549	14,643	17,243
	OTHER REIMBURS COST CNTRS AMBULANCE SERVICES			
65	TOTAL		1,634,165	429,063
101	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
102	NET CHARGES		1,634,165	
103				

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET E
 I COMPONENT NO: I TO 12/31/2010 I PART B
 I 15-1322 I I

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) 3,621,941
 1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1,
 2001 (SEE INSTRUCTIONS).
 1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.
 1.03 ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.
 1.04 LINE 1.01 TIMES LINE 1.03.
 1.05 LINE 1.02 DIVIDED BY LINE 1.04.
 1.06 TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)
 1.07 OUTPATIENT ANCILLARY PASSTHRU COSTS FROM (W/S D,IV
 (COLS 9, 9.01, 9.02) LINE 101
 2 INTERNS AND RESIDENTS
 3 ORGAN ACQUISITIONS
 4 COST OF TEACHING PHYSICIANS
 5 TOTAL COST (SEE INSTRUCTIONS) 3,621,941

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) 3,658,160
 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

CAH DEDUCTIBLES 42,634
 01 CAH ACTUAL BILLED COINSURANCE 2,158,904
 LINE 17.01 (SEE INSTRUCTIONS)
 19 SUBTOTAL (SEE INSTRUCTIONS) 1,456,622
 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 1,456,622
 24 PRIMARY PAYER PAYMENTS 57
 25 SUBTOTAL 1,456,565

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26 COMPOSITE RATE ESRD
 27 BAD DEBTS (SEE INSTRUCTIONS) 379,810
 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) 379,810
 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES 318,050
 28 SUBTOTAL 1,836,375
 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 1,836,375
 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)
 34 INTERIM PAYMENTS 1,668,436
 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)
 35 BALANCE DUE PROVIDER/PROGRAM 167,939
 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 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-1322 I I

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				
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.		4,577,242		1,669,016
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)		NONE		NONE
ADJUSTMENTS TO PROVIDER .01	8/12/2010	168,263		
ADJUSTMENTS TO PROVIDER .02	12/23/2010	114,657		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROVIDER .49				
ADJUSTMENTS TO PROGRAM .50			8/12/2010	580
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		282,920		-580
4 TOTAL INTERIM PAYMENTS		4,860,162		1,668,436
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL .99		NONE		NONE
DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				167,939
7 TOTAL MEDICARE PROGRAM LIABILITY		4,738,491		1,836,375

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.

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-Z322 I I

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		871,969		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01	8/12/2010	40,600		
ADJUSTMENTS TO PROVIDER .02	12/23/2010	16,965		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROVIDER .49				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL		57,565		NONE
4 TOTAL INTERIM PAYMENTS		929,534		NONE
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL		NONE		NONE
DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		44,638		
7 TOTAL MEDICARE PROGRAM LIABILITY		884,896		

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I
 I COMPONENT NO: I TO 12/31/2010 I WORKSHEET E-2
 I 15-2322 I I

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A 1	PART B 2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	688,893	
2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3 ANCILLARY SERVICES (SEE INSTRUCTIONS)	215,116	
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5 PROGRAM DAYS	662	
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8 SUBTOTAL	904,009	
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10 SUBTOTAL	904,009	
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12 SUBTOTAL	904,009	
13 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS) (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	19,113	
14 80% OF PART B COSTS		
15 SUBTOTAL	884,896	
16 OTHER ADJUSTMENTS (SPECIFY)		
17 REIMBURSABLE BAD DEBTS		
17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18 TOTAL	884,896	
19 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20 INTERIM PAYMENTS	929,534	
20.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21 BALANCE DUE PROVIDER/PROGRAM	-44,638	
22 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET E-3
 I COMPONENT NO: I TO 12/31/2010 I PART II
 I 15-1322 I I

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	5,169,614
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	5,169,614
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	5,221,310
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	5,221,310
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	571,638
21	EXCESS REASONABLE COST	
22	SUBTOTAL	4,649,672
23	COINSURANCE	22,550
24	SUBTOTAL	4,627,122
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	111,369
26.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	111,369
26.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	97,201
26	SUBTOTAL	4,738,491
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	4,738,491
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	4,860,162
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	-121,671
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	7,380,686			
2	TEMPORARY INVESTMENTS	8,185,503			
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	10,465,565			
5	OTHER RECEIVABLES	-663,336			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-4,097,031			
7	INVENTORY	605,278			
8	PREPAID EXPENSES	612,443			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	22,489,108			
FIXED ASSETS					
12	LAND				
12.01					
13	LAND IMPROVEMENTS				
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	30,915,443			
14.01	LESS ACCUMULATED DEPRECIATION	-18,146,738			
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	12,768,705			
OTHER ASSETS					
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	999,636			
26	TOTAL OTHER ASSETS	999,636			
	TOTAL ASSETS	36,257,449			

BALANCE SHEET

I
I
IPROVIDER NO:
15-1322

I PERIOD:

I FROM 1/ 1/2010

I TO 12/31/2010

I PREPARED 5/25/2011

I

I WORKSHEET G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	546,174			
29 SALARIES, WAGES & FEES PAYABLE	774,998			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	823,529			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS	632,619			
35 OTHER CURRENT LIABILITIES	806,337			
36 TOTAL CURRENT LIABILITIES	3,583,657			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE	2,466,088			
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	2,466,088			
43 TOTAL LIABILITIES	6,049,745			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	30,207,704			
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	30,207,704			
52 TOTAL LIABILITIES AND FUND BALANCES	36,257,449			

STATEMENT OF CHANGES IN FUND BALANCES

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET G-1
 I I TO 12/31/2010 I

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING		27,870,221		
2 OF PERIOD				
3 NET INCOME (LOSS)		2,366,026		
4 TOTAL		30,236,247		
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
6 ADDITIONS (CREDIT ADJUSTM				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL		30,236,247		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM		28,543		
14				
15				
16				
17				
18 TOTAL DEDUCTIONS		28,543		
19 FUND BALANCE AT END OF		30,207,704		
PERIOD PER BALANCE SHEET				

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET G-2
 I I TO 12/31/2010 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	3,264,333		3,264,333
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	3,264,333		3,264,333
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT	1,198,174		1,198,174
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	1,198,174		1,198,174
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	4,462,507		4,462,507
17 00 ANCILLARY SERVICES	15,241,446	38,800,831	54,042,277
18 00 OUTPATIENT SERVICES			
19 00 HOME HEALTH AGENCY		1,286,749	1,286,749
20 00 AMBULANCE SERVICES		1,800,206	1,800,206
24 00	122,015	3,404,923	3,526,938
25 00 TOTAL PATIENT REVENUES	19,825,968	45,292,709	65,118,677

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		29,757,701	
ADD (SPECIFY)			
27 00 BAD DEBT	3,625,321		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		3,625,321	
DEDUCT (SPECIFY)			
34 00 NON OPERATING EXPENSES	3,827,986		
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS		3,827,986	
40 00 TOTAL OPERATING EXPENSES		29,555,036	

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET G-3
 I I TO 12/31/2010 I

DESCRIPTION

1	TOTAL PATIENT REVENUES	65,118,677
2	LESS: ALLOWANCES AND DISCOUNTS ON	31,955,067
3	NET PATIENT REVENUES	33,163,610
4	LESS: TOTAL OPERATING EXPENSES	29,555,036
5	NET INCOME FROM SERVICE TO PATIENT	3,608,574
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER REV	196,035
24.01	NON OPERATING REV	3,335,710
24.02	INVESTMENTS	297,801
25	TOTAL OTHER INCOME	3,829,546
26	TOTAL	7,438,120
	OTHER EXPENSES	
27	NON OPERATING EXP	5,072,094
28		
29		
30	TOTAL OTHER EXPENSES	5,072,094
31	NET INCOME (OR LOSS) FOR THE PERIO	2,366,026

HHA 1

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPORTATION 3	CONTRACTED/ PURCHASED SVCS 4	OTHER COSTS 5	TOTAL 6
GENERAL SERVICE COST CENTERS						
1						
2						
3						
4						
5	99,904		2,601	1,203	114,010	217,718
HHA REIMBURSABLE SERVICES						
6	104,570		8,485			113,055
7			4,552	65,109		69,661
8			1,869	27,080		28,949
9				2,760		2,760
10	6,968		567			7,535
11	32,181		3,294			35,475
12					3,483	3,483
13						
13.20						
14						
HHA NONREIMBURSABLE SERVICES						
15						
16						
17						
18						
19						
20						
21						
22						
23						
23.50						
24	243,623		21,368	96,152	117,493	478,636

	RECLASSIFI- CATIONS 7	RECLASSIFIED TRIAL BALANCE 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION 10
GENERAL SERVICE COST CENTERS				
1				
2				
3				
4				
5	71,872	289,590	-760	288,830
HHA REIMBURSABLE SERVICES				
6		113,055		113,055
7		69,661		69,661
8		28,949		28,949
9		2,760		2,760
10		7,535		7,535
11		35,475		35,475
12		3,483		3,483
13				
13.20				
14				
HHA NONREIMBURSABLE SERVICES				
15				
16				
17				
18				
19				
20				
21				
22				
23				
23.50				
24	71,872	550,508	-760	549,748

HHA 1

	NET EXPENSES FOR COST ALLOCATION	CAP-REL COST-BLDG & FIX	CAP-REL COST-MOV EQUIP	PLANT OPER & MAINT	TRANSPORTATIO N	SUBTOTAL	ADMINISTRATIV E & GENERAL
	0	1	2	3	4	4A	5
GENERAL SERVICE COST CENTERS							
1							
2							
3							
4							
5							
	288,830					288,830	288,830
HHA REIMBURSABLE SERVICES							
6	113,055					113,055	125,149
7	69,661					69,661	77,113
8	28,949					28,949	32,046
9	2,760					2,760	3,055
10	7,535					7,535	8,341
11	35,475					35,475	39,270
12	3,483					3,483	3,856
13							
13.20							
14							
HHA NONREIMBURSABLE SERVICES							
15							
16							
17							
18							
19							
20							
21							
22							
23							
23.50							
24	549,748					549,748	
TOTAL (SUM OF LINES 1-23)							

TOTAL

6

GENERAL SERVICE COST CENTERS							
4							
5							
HHA REIMBURSABLE SERVICES							
6	238,204						
7	146,774						
8	60,995						
9	5,815						
10	15,876						
11	74,745						
12	7,339						
13							
13.20							
14							
HHA NONREIMBURSABLE SERVICES							
15							
16							
17							
18							
19							
20							
21							
22							
23							
23.50							
24	549,748						
TOTAL (SUM OF LINES 1-23)							

HHA 1

	CAP-REL COST-BLDG & FIX (SQUARE FEET)	CAP-REL COST-MOV EQUIP (DOLLAR VALUE)	PLANT OPER & MAINT (SQUARE FEET)	TRANSPORTATIO N (MILEAGE)	RECONCILIATIO N (5A	ADMINISTRATIV E & GENERAL (ACCUM. COST)
	1	2	3	4		5
GENERAL SERVICE COST CENTERS						
1	CAP-REL COST-BLDG & FIX					
2	CAP-REL COST-MOV EQUIP					
3	PLANT OPER & MAINT					
4	TRANSPORTATION					
5	ADMINISTRATIVE & GENERAL				-288,830	260,918
HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE					113,055
7	PHYSICAL THERAPY					69,661
8	OCCUPATIONAL THERAPY					28,949
9	SPEECH PATHOLOGY					2,760
10	MEDICAL SOCIAL SERVICES					7,535
11	HOME HEALTH AIDE					35,475
12	SUPPLIES					3,483
13	DRUGS					
13.20	COST ADMINISTERING DRUGS					
14	DME					
HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SVCS					
16	RESPIRATORY THERAPY					
17	PRIVATE DUTY NURSING					
18	CLINIC					
19	HEALTH PROM ACTIVITIES					
20	DAY CARE PROGRAM					
21	HOME DEL MEALS PROGRAM					
22	HOMEMAKER SERVICE					
23	ALL OTHERS					
23.50	TELEMEDICINE					
24	TOTAL (SUM OF LINES 1-23)				-288,830	260,918
25	COST TO BE ALLOCATED					288,830
26	UNIT COST MULTIPLIER					1.106976

HHA 1

HHA COST CENTER	HHA TRIAL BALANCE (1) 0	NEW CAP REL COSTS-BLDG & 3	NEW CAP REL COSTS-MVBLE 4	EMPLOYEE BEN EFITS 5	SUBTOTAL 5A	ADMINISTRATI VE & GENERAL 6
1 ADMIN & GENERAL		9,237	1,022	11,084	21,343	3,963
2 SKILLED NURSING CARE	238,204				238,204	44,224
3 PHYSICAL THERAPY	146,774				146,774	27,250
4 OCCUPATIONAL THERAPY	60,995				60,995	11,324
5 SPEECH PATHOLOGY	5,815				5,815	1,080
6 MEDICAL SOCIAL SERVICES	15,876				15,876	2,948
7 HOME HEALTH AIDE	74,745				74,745	13,877
8 SUPPLIES	7,339				7,339	1,363
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	549,748	9,237	1,022	11,084	571,091	106,029
21 UNIT COST MULTIPLIER						

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

HHA COST CENTER	OPERATION OF PLANT 8	LAUNDRY & LI NEN SERVICE 9	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMI NISTRATION 14
1 ADMIN & GENERAL	15,788		4,732			
2 SKILLED NURSING CARE						
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	15,788		4,732			
21 UNIT COST MULTIPLIER						

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

HHA 1

HHA COST CENTER	MEDICAL RECO RDS & LIBRAR	SUBTOTAL	POST DOWN	STEP ADJUST	SUBTOTAL	ALLOCATED HHA A & G	TOTAL HHA COSTS
	17	25		26	27	28	29
1 ADMIN & GENERAL		45,826			45,826		
2 SKILLED NURSING CARE		282,428			282,428	19,856	302,284
3 PHYSICAL THERAPY		174,024			174,024	12,235	186,259
4 OCCUPATIONAL THERAPY		72,319			72,319	5,084	77,403
5 SPEECH PATHOLOGY		6,895			6,895	485	7,380
6 MEDICAL SOCIAL SERVICES		18,824			18,824	1,323	20,147
7 HOME HEALTH AIDE		88,622			88,622	6,231	94,853
8 SUPPLIES		8,702			8,702	612	9,314
9 DRUGS							
9.20 COST ADMINISTERING DRUGS							
10 DME							
11 HOME DIALYSIS AIDE SVCS							
12 RESPIRATORY THERAPY							
13 PRIVATE DUTY NURSING							
14 CLINIC							
15 HEALTH PROM ACTIVITIES							
16 DAY CARE PROGRAM							
17 HOME DEL MEALS PROGRAM							
18 HOMEMAKER SERVICE							
19 ALL OTHER							
19.50 TELEMEDICINE							
20 TOTAL (SUM OF 1-19) (2)		697,640			697,640	45,826	697,640
21 UNIT COST MULTIPLIER						0.070305	

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

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

HHA 1

HHA COST CENTER	NEW CAP REL COSTS-BLDG & COSTS (SQUARE FEET) 3	NEW CAP REL COSTS-MVBLE COSTS (SQUARE FEET) 4	EMPLOYEE BENEFITS (GROSS SALARIES) 5	RECONCILIATION 6A	ADMINISTRATIVE & GENERAL ACCUM. COST 6	OPERATION OF PLANT (SQUARE FEET) 8
1 ADMIN & GENERAL	588	588	243,643		21,343	588
2 SKILLED NURSING CARE					238,204	
3 PHYSICAL THERAPY					146,774	
4 OCCUPATIONAL THERAPY					60,995	
5 SPEECH PATHOLOGY					5,815	
6 MEDICAL SOCIAL SERVICES					15,876	
7 HOME HEALTH AIDE					74,745	
8 SUPPLIES					7,339	
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)	588	588	243,643		571,091	588
21 COST TO BE ALLOCATED	9,237	1,022	11,084		106,029	15,788
22 UNIT COST MULTIPLIER	15.709184	1.738095	0.045493		0.185660	26.850340

HHA COST CENTER	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 9	HOUSEKEEPING (SQUARE FEET) 10	DIETARY (MEALS SERVED) 11	CAFETERIA (FTE'S) 12	NURSING ADMINISTRATION (DIRECT SING HRS) 14	MEDICAL RECORDS & LIBRARY (TIME SPENT) 17
1 ADMIN & GENERAL		588				
2 SKILLED NURSING CARE						
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)		588				
21 COST TO BE ALLOCATED		4,732				
22 UNIT COST MULTIPLIER		8.047619				

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET H-6
 I HHA NO: I TO 12/31/2010 I PARTS I II & III
 I 15-7177 I I HHA 1

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

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

COST PER VISIT COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	PROGRAM VISITS
							PART A 6
1 SKILLED NURSING	2	302,284		302,284	1,728	174.93	546
2 PHYSICAL THERAPY	3	186,259		186,259	1,206	154.44	650
3 OCCUPATIONAL THERAPY	4	77,403		77,403	427	181.27	216
4 SPEECH PATHOLOGY	5	7,380		7,380	39	189.23	25
5 MEDICAL SOCIAL SERVICES	6	20,147		20,147	266	75.74	23
6 HOME HEALTH AIDE SERVICE	7	94,853		94,853	1,272	74.57	238
7 TOTAL		688,326		688,326	4,938		1,698

	-----PROGRAM VISITS-----		-----COST OF SERVICES-----		TOTAL PROGRAM COST
	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	PART A	SUBJECT TO DEDUCT & COINSUR	
1 SKILLED NURSING	7	514	9	89,914	185,426
2 PHYSICAL THERAPY		258	100,386	39,846	140,232
3 OCCUPATIONAL THERAPY		93	39,154	16,858	56,012
4 SPEECH PATHOLOGY		10	4,731	1,892	6,623
5 MEDICAL SOCIAL SERVICES		21	1,742	1,591	3,333
6 HOME HEALTH AIDE SERVICES		180	17,748	13,423	31,171
7 TOTAL		1,076	259,273	163,524	422,797

LIMITATION COST COMPUTATION	PROGRAM COST LIMITS					PROGRAM VISITS
PATIENT SERVICES	1	2	3	4	5	PART A 6
SKILLED NURSING	9915					
PHYSICAL THERAPY	9915					
10 OCCUPATIONAL THERAPY	9915					
11 SPEECH PATHOLOGY	9915					
12 MEDICAL SOCIAL SERVICES	9915					
13 HOME HEALTH AIDE SERVICE	9915					
14 TOTAL						

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

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-1322 I FROM 1/ 1/2010 I WORKSHEET H-6
 I HHA NO: I TO 12/31/2010 I PARTS I II & III
 I 15-7177 I I HHA 1

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

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

SUPPLIES AND EQUIPMENT COST COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I) 1	SHARED ANCILLARY COSTS (FROM PART II) 2	TOTAL HHA COSTS 3	TOTAL CHARGES 4	RATIO 5	PROGRAM COVERED CHARGES PART A 6
15 COST OF MEDICAL SUPPLIES	8.00	9,314		9,314	35,373	.263308	18,906
16 COST OF DRUGS	9.00						
16.20 COST OF DRUGS	9.20						

	PROGRAM COVERED CHARGES		-----COST OF SERVICES-----	
	NOT SUBJECT TO DEDUCT & COINSUR 7	SUBJECT TO DEDUCT & COINSUR 8	NOT SUBJECT TO DEDUCT & COINSUR 9	SUBJECT TO DEDUCT & COINSUR 11
15 COST OF MEDICAL SUPPLIES	5,433		4,978	1,431
16 COST OF DRUGS				
16.20 COST OF DRUGS				

PER BENEFICIARY COST LIMITATION:

	MSA NUMBER 1	AMOUNT 2
162 PROGRAM UN DUP CENSUS FROM WRKST 5-4	9915	
17 PER BENE COST LIMITATION (FRM FI)	9915	
18 PER BENE COST LIMITATION (LN 17*18)		

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

	FROM WKST C PT I, COL 9	COST TO CHARGE RATIO 1	TOTAL HHA CHARGES 2	HHA SHARED ANCILLARY COSTS 3	TRANSFER TO PART I AS INDICATED 4
1 PHYSICAL THERAPY	50	.514881			COL 2, LN 2
2 OCCUPATIONAL THERAPY	51	.382854			COL 2, LN 3
3 SPEECH PATHOLOGY	52	.368256			COL 2, LN 4
4 MEDICAL SUPPLIES CHARGED TO PATIENT	55	.124032			COL 2, LN 15
4.30 IMPL. DEV. CHARGED TO PATIENT	55.30	.429202			
5 DRUGS CHARGED TO PATIENTS	56	.232942			COL 2, LN 16

PART III - OUTPATIENT THERAPY REDUCTION COMPUTATION

	FROM PART I, COL 5 1	COST PER VISIT 2	PART B SERVICES SUBJECT TO DEDUCTIBLES AND COINSURANCE		PROGRAM VISITS ON OR AFTER 1/1/1999 5
			PROGRAM VISITS PRIOR 1/1/1998 3	PROGRAM COSTS PRIOR 1/1/1998 4	
1 PHYSICAL THERAPY	2	154.44	2.01	3.01	
2 OCCUPATIONAL THERAPY	3	181.27			
3 SPEECH PATHOLOGY	4	189.23			
4 TOTAL (SUM OF LINES 1-3)					

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

TITLE XVIII HHA 1

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

	PART A	PART B NOT SUBJECT TO DED & COINS	PART B SUBJECT TO DED & COINS
	1	2	3
1 REASONABLE COST OF SERVICES			
2 TOTAL CHARGES	437,442	285,164	
3 CUSTOMARY CHARGES			
4 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
5 AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(B)			
6 RATIO OF LINE 3 TO 4 (NOT TO EXCEED 1.000000)			
7 TOTAL CUSTOMARY CHARGES	437,442	285,164	
8 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST	437,442	285,164	
9 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES PRIMARY PAYOR AMOUNTS			

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	PART A SERVICES	PART B SERVICES
	1	2
10 TOTAL REASONABLE COST		
10.01 TOTAL PPS REIMBURSEMENT-FULL EPISODES WITHOUT OUTLIERS	261,348	148,524
10.02 TOTAL PPS REIMBURSEMENT-FULL EPISODES WITH OUTLIERS		4,928
10.03 TOTAL PPS REIMBURSEMENT-LUPA EPISODES	5,062	3,680
10.04 TOTAL PPS REIMBURSEMENT-PEP EPISODES	1,953	
10.05 TOTAL PPS REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.06 TOTAL PPS REIMBURSEMENT-SCIC EPISODES		
10.07 TOTAL PPS OUTLIER REIMBURSEMENT-FULL EPISODES WITH OUTLIERS		555
10.08 TOTAL PPS OUTLIER REIMBURSEMENT-PEP EPISODES		
10.09 TOTAL PPS OUTLIER REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.10 TOTAL PPS OUTLIER REIMBURSEMENT-SCIC EPISODES		
10.11 TOTAL OTHER PAYMENTS		
10.12 DME PAYMENTS		
10.13 OXYGEN PAYMENTS		
10.14 PROSTHETIC AND ORTHOTIC PAYMENTS		
11 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)		
12 SUBTOTAL	268,363	157,687
13 EXCESS REASONABLE COST		
14 SUBTOTAL	268,363	157,687
15 COINSURANCE BILLED TO PROGRAM PATIENTS		
16 NET COST	268,363	157,687
17 REIMBURSABLE BAD DEBTS		
17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18 TOTAL COSTS - CURRENT COST REPORTING PERIOD	268,363	157,687
19 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
20 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR DECREASE IN MEDICARE UTILIZATION		
21 OTHER ADJUSTMENTS (SPECIFY)		
22 SUBTOTAL	268,363	157,687
23 SEQUESTRATION ADJUSTMENT		
24 SUBTOTAL	268,363	157,687
25 INTERIM PAYMENTS	268,363	157,687
25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26 BALANCE DUE PROVIDER/PROGRAM		
27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II SECTION 115.2		

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

I PROVIDER NO: 15-1322
I HHA NO: 15-7177
I PERIOD: FROM 1/1/2010 TO 12/31/2010
I PREPARED 5/25/2011
I WORKSHEET H-8

TITLE XVIII HHA 1

DESCRIPTION	P A R T 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		268,363		157,687
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				
SUBTOTAL		.99		
4 TOTAL INTERIM PAYMENTS			NONE 268,363	NONE 157,687
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL		.99	NONE	NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02				
TOTAL MEDICARE PROGRAM LIABILITY			268,363	157,687

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF CAPITAL PAYMENT

TITLE XIX HOSPITAL

PART I - FULLY PROSPECTIVE METHOD

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

PART II - HOLD HARMLESS METHOD

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

PART III - PAYMENT UNDER REASONABLE COST

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