

**ST. VINCENT CLAY HOSPITAL
BRAZIL, INDIANA**

**PROVIDER NO. 15-1309 and 15-Z309
AND AIM NO. 200448850**

**HOSPITAL STATEMENTS OF REIMBURSABLE COSTS
(MEDICARE AND MEDICAID PROGRAMS)**

JUNE 30, 2010

ST. VINCENT CLAY HOSPITAL

**PROVIDER NOS. 15-1309 and 15-Z309
AND AIM NO. 200448850**

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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Board of Directors
St. Vincent Clay Hospital
Brazil, Indiana

We have compiled the Hospital Statements of Reimbursable Costs (Title XVIII and XIX) of St. Vincent Clay Hospital for the year ended June 30, 2010 in the accompanying prescribed form in accordance with Statements on Standards for Accounting Review Services issued by the American Institute of Certified Public Accountants.

Our compilation was limited to presenting in the form prescribed by the Centers for Medicare and Medicaid Services, information that is the representation of management. We have not audited or reviewed the report referred to above and, accordingly, do not express an opinion or any other form of assurance on it.

The report is presented in accordance with the requirements of the Centers for Medicare and Medicaid Services, which differ from generally accepted accounting principles. Accordingly, this report is not designed for those who are not informed about such differences.

This report is intended to be filed with the Centers for Medicare and Medicaid Services and should not be used for any other purposes.

Bradley Associates, Inc.

November 30, 2010

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	I	15-1309	I	FROM 7/ 1/2009	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 6/30/2010	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
						--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 11/30/2010 TIME 11:18

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:
 ST. VINCENT CLAY HOSPITAL 15-1309
 FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2009 AND ENDING 6/30/2010 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: 11/30/2010 TIME 11:18

qAgkIaC6qo6QXVNZ1fqN8urCEatzV0
 HoOG20MBRa9mYMr8omzyv9w8ezJYSy
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PI ENCRYPTION INFORMATION
 DATE: 11/30/2010 TIME 11:18

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OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2		3	4	
1	HOSPITAL	0	26,710		42,976	135
3	SWING BED - SNF	0	40,067		0	0
100	TOTAL	0	66,777		42,976	135

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

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

MCRIF32 1.22.0.0 ~ 2552-96 22.0.122.3

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS
 1 STREET: 1206 EAST NATIONAL AVENUE P.O. BOX:
 1.01 CITY: BRAZIL STATE: IN ZIP CODE: 47834- COUNTY: CLAY

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N)		
0	1	2	2.01	3	V	XVIII	XIX
02.00 HOSPITAL	ST. VINCENT CLAY HOSPITAL	15-1309		8/ 8/2001	N	0	N
04.00 SWING BED - SNF	ST. VINCENT CLAY SWING BEDS	15-2309		8/ 8/2001	N	0	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 7/ 1/2009 TO: 6/30/2010

18 TYPE OF CONTROL

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL

20 SUBPROVIDER

OTHER INFORMATION

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

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

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.

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

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

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

21.07 DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER "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 SECTION 3121? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. (SEE INSTRUCTIONS)

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

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 8/ 8/2001

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

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

	1	2	3	4
28.02	0.00	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

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). N

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

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

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

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

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

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

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

MISCELLANEOUS COST REPORT INFORMATION

32 IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2. N

33 IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2 N

34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA? N

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

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

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

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

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

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

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

40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS). Y
 40.01 NAME: ST. VINCENT HEALTH FI/CONTRACTOR NAME NATIONAL GOVERNMENT SERVICES FI/CONTRACTOR # 15H046
 40.02 STREET: 10330 N. MERIDIAN ST. SUITE 420 P.O. BOX:
 40.03 CITY: INDIANAPOLIS STATE: IN ZIP CODE: 46290-
 41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? 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 NHCMP DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

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

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

52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N
 52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV N
 53 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0
 53.01 MDH PERIOD: BEGINNING: / / ENDING: / /
 54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
 PREMIUMS: 66,187
 PAID LOSSES: 0
 AND/OR SELF INSURANCE: 0
 54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N
 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

	DATE	Y OR N	LIMIT	Y OR N	FEES
	0	1	2	3	4
56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		N	0.00		0
56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0

- 57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N
- 58 ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER?
 ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100%
 FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS
 ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE
 10/1/2002. N
- 58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST
 REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS
 THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC.
 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER
 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD
 COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS
 OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).
- 59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO.
 IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2
 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N
- 60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER?
 ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW
 FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N
- 60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN
 THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y"
 FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN
 ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(C)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF
 COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST
 REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT
 ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC). 0

MULTICAMPUS

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

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00

SETTLEMENT DATA

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

COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	I/P DAYS / TITLE V	O/P VISITS / TITLE XVIII	TRIPS / TITLE XIX
1 ADULTS & PEDIATRICS	25	9,125	46,224.00	3	4	5
2 HMO					1,403	148
2 01 HMO - (IRF PPS SUBPROVIDER)						
3 ADULTS & PED-SB SNF					1,210	
4 ADULTS & PED-SB NF						
5 TOTAL ADULTS AND PEDS	25	9,125	46,224.00		2,613	148
6 INTENSIVE CARE UNIT						
7 CORONARY CARE UNIT						
8 BURN INTENSIVE CARE UNIT						
9 SURGICAL INTENSIVE CARE UNIT						
11 NURSERY						
12 TOTAL	25	9,125	46,224.00		2,613	148
13 RPCH VISITS						
14 SUBPROVIDER						
15 SKILLED NURSING FACILITY						
16 NURSING FACILITY						
16 01 ICF/MR						
17 OTHER LONG TERM CARE						
18 HOME HEALTH AGENCY						
20 AMBULATORY SURGICAL CENTER (
21 HOSPICE						
23 CORF						
25 TOTAL	25					
26 OBSERVATION BED DAYS						
27 AMBULANCE TRIPS						
28 EMPLOYEE DISCOUNT DAYS						
28 01 EMP DISCOUNT DAYS -IRF						
29 LABOR & DELIVERY DAYS						

COMPONENT	TITLE XIX OBSERVATION BEDS ADMITTED	I/P DAYS / NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	/ TRIPS / TOTAL OBSERVATION BEDS ADMITTED	DISCHARGES / TOTAL OBSERVATION BEDS NOT ADMITTED	INTERNS & RES. FTES / TOTAL	LESS I&R REPL NON-PHYS ANES /
1 ADULTS & PEDIATRICS	5.01	5.02	6	6.01	6.02	7	8
2 HMO			1,926				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			1,210				
4 ADULTS & PED-SB NF			150				
5 TOTAL ADULTS AND PEDS			3,286				
6 INTENSIVE CARE UNIT							
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL			3,286				
13 RPCH VISITS							
14 SUBPROVIDER							
15 SKILLED NURSING FACILITY							
16 NURSING FACILITY							
16 01 ICF/MR							
17 OTHER LONG TERM CARE							
18 HOME HEALTH AGENCY							
20 AMBULATORY SURGICAL CENTER (
21 HOSPICE							
23 CORF							
25 TOTAL			506	51	455		
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS			36				
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	I & R FTES NET	--- FULL TIME EQUIV EMPLOYEES ON PAYROLL	NONPAID WORKERS	DISCHARGES / TITLE V	DISCHARGES / TITLE XVIII	DISCHARGES / TITLE XIX	TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2 HMO					409	46	595
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							
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL		151.89			409	46	595
13 RPCH VISITS							
14 SUBPROVIDER							

HOSPITAL AND HOSPITAL HEALTH CARE
 COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET S-3
 I I TO 6/30/2010 I PART I

COMPONENT	I & R FTES NET	--- FULL TIME EQUIV ---		DISCHARGES			TOTAL ALL PATIENTS
		EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	
15 SKILLED NURSING FACILITY	9	10	11	12	13	14	15
16 NURSING FACILITY							
16 01 ICF/MR							
17 OTHER LONG TERM CARE							
18 HOME HEALTH AGENCY							
20 AMBULATORY SURGICAL CENTER (
21 HOSPICE							
23 CORF							
25 TOTAL		151.89					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO:
I 15-1309
I

I PERIOD:
I FROM 7/ 1/2009
I TO 6/30/2010

I PREPARED 11/30/2010
I WORKSHEET A
I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
1	0100 OLD CAP REL COSTS-BLDG & FIXT					
2	0200 OLD CAP REL COSTS-MVBLE EQUIP					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		450,268	450,268	-182,178	268,090
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		1,053,429	1,053,429	136,860	1,190,289
4.01	0401 NEW CAP REL COSTS-MOB BLD		351,540	351,540		351,540
5	0500 EMPLOYEE BENEFITS	107,079	2,176,904	2,283,983		2,283,983
6	0600 ADMINISTRATIVE & GENERAL	1,615,021	1,525,688	3,140,709	64,086	3,204,795
7	0700 MAINTENANCE & REPAIRS					
8	0800 OPERATION OF PLANT	300,792	428,650	729,442		729,442
9	0900 LAUNDRY & LINEN SERVICE		77,354	77,354		77,354
10	1000 HOUSEKEEPING	217,858	59,640	277,498		277,498
11	1100 DIETARY	252,605	99,182	351,787	-187,326	164,461
12	1200 CAFETERIA				187,326	187,326
13	1300 MAINTENANCE OF PERSONNEL					
14	1400 NURSING ADMINISTRATION	182,860	15,664	198,524	21,208	219,732
15	1500 CENTRAL SERVICES & SUPPLY		111,150	111,150	-79	111,071
16	1600 PHARMACY		400,659	400,659	-57	400,602
17	1700 MEDICAL RECORDS & LIBRARY	299,205	16,465	315,670		315,670
18	1800 SOCIAL SERVICE					
20	2000 NONPHYSICIAN ANESTHETISTS					
21	2100 NURSING SCHOOL					
22	2200 I&R SERVICES-SALARY & FRINGES APPRVD					
23	2300 I&R SERVICES-OTHER PRGM COSTS APPRVD					
24	2400 PARAMED ED PRGM					
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	1,002,546	71,864	1,074,410	-7,958	1,066,452
26	2600 INTENSIVE CARE UNIT					
27	2700 CORONARY CARE UNIT					
28	2800 BURN INTENSIVE CARE UNIT					
29	2900 SURGICAL INTENSIVE CARE UNIT					
31	3100 SUBPROVIDER					
33	3300 NURSERY					
34	3400 SKILLED NURSING FACILITY					
35	3500 NURSING FACILITY					
35.01	3510 ICF/MR					
36	3600 OTHER LONG TERM CARE					
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	499,613	276,867	776,480	-147,319	629,161
38	3800 RECOVERY ROOM					
39	3900 DELIVERY ROOM & LABOR ROOM					
40	4000 ANESTHESIOLOGY	326,128	7,983	334,111		334,111
41	4100 RADIOLOGY-DIAGNOSTIC	590,486	379,698	970,184	-61,055	909,129
42	4200 RADIOLOGY-THERAPEUTIC					
43	4300 RADIOISOTOPE					
44	4400 LABORATORY	376,091	734,873	1,110,964		1,110,964
45	4500 PBP CLINICAL LAB SERVICES-PRGM ONLY					
46	4600 WHOLE BLOOD & PACKED RED BLOOD CELLS					
47	4700 BLOOD STORING, PROCESSING & TRANS.					
48	4800 INTRAVENOUS THERAPY					
49	4900 RESPIRATORY THERAPY	139,483	46,351	185,834	-31,271	154,563
50	5000 PHYSICAL THERAPY		557,592	557,592		557,592
51	5100 OCCUPATIONAL THERAPY					
52	5200 SPEECH PATHOLOGY		1,744	1,744		1,744
53	5300 ELECTROCARDIOLOGY	115,293	12,825	128,118		128,118
54	5400 ELECTROENCEPHALOGRAPHY					
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		529,496	529,496	74,176	603,672
55.30	5530 IMPL. DEV. CHARGED TO PATIENT				168,476	168,476
56	5600 DRUGS CHARGED TO PATIENTS		809,257	809,257	18,837	828,094
57	5700 RENAL DIALYSIS					
58	5800 ASC (NON-DISTINCT PART)					
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC					
61	6100 EMERGENCY	703,976	683,046	1,387,022	-13,750	1,373,272
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
64	6400 HOME PROGRAM DIALYSIS					
65	6500 AMBULANCE SERVICES					
66	6600 DURABLE MEDICAL EQUIP-RENTED					
67	6700 DURABLE MEDICAL EQUIP-SOLD					
69	6900 CORF					
70	7000 I&R SERVICES-NOT APPRVD PRGM					
71	7100 HOME HEALTH AGENCY					
	SPEC PURPOSE COST CENTERS					
82	8200 LUNG ACQUISITION					
83	8300 KIDNEY ACQUISITION					
84	8400 LIVER ACQUISITION					
85	8500 HEART ACQUISITION					
86	8600 OTHER ORGAN ACQUISITION					
88	8800 INTEREST EXPENSE					
89	8900 UTILIZATION REVIEW-SNF					
90	9000 OTHER CAPITAL RELATED COSTS					
92	9200 AMBULATORY SURGICAL CENTER (D.P.)					
93	9300 HOSPICE					
95	SUBTOTALS	6,729,036	10,878,189	17,607,225	39,976	17,647,201
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
I 15-1309 I FROM 7/ 1/2009 I WORKSHEET A
I I TO 6/30/2010 I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
NONREIMBURS COST CENTERS						
97	9700 RESEARCH					
98	9800 PHYSICIANS' PRIVATE OFFICES					
98.01	9801 PHYSICIANS' PRIVATE OFFICES		13,984	13,984		13,984
98.02	9802 CLAY COUNTY - CLINIC	183,535	109,923	293,458	-49	293,409
98.03	9803 MISSION SERVICES		185	185		185
98.04	9804 PUBLIC RELATIONS	42,416	20,140	62,556	-39,927	22,629
99	9900 NONPAID WORKERS					
100	7950 OTHER NONREIMBURSABLE COST CENTERS					
101	TOTAL	6,954,987	11,022,421	17,977,408	-0-	17,977,408

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
I 15-1309 I FROM 7/ 1/2009 I WORKSHEET A
I I TO 6/30/2010 I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
1	0100 OLD CAP REL COSTS-BLDG & FIXT		
2	0200 OLD CAP REL COSTS-MVBLE EQUIP		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	174,016	442,106
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-125,958	1,064,331
4.01	0401 NEW CAP REL COSTS-MOB BLD		351,540
5	0500 EMPLOYEE BENEFITS	-130,936	2,153,047
6	0600 ADMINISTRATIVE & GENERAL	393,494	3,598,289
7	0700 MAINTENANCE & REPAIRS		
8	0800 OPERATION OF PLANT	-2,168	727,274
9	0900 LAUNDRY & LINEN SERVICE		77,354
10	1000 HOUSEKEEPING		277,498
11	1100 DIETARY		164,461
12	1200 CAFETERIA	-40,937	146,389
13	1300 MAINTENANCE OF PERSONNEL		
14	1400 NURSING ADMINISTRATION		219,732
15	1500 CENTRAL SERVICES & SUPPLY		111,071
16	1600 PHARMACY		400,602
17	1700 MEDICAL RECORDS & LIBRARY		315,670
18	1800 SOCIAL SERVICE		
20	2000 NONPHYSICIAN ANESTHETISTS		
21	2100 NURSING SCHOOL		
22	2200 I&R SERVICES-SALARY & FRINGES APPRVD		
23	2300 I&R SERVICES-OTHER PRGM COSTS APPRVD		
24	2400 PARAMED ED PRGM		
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS		1,066,452
26	2600 INTENSIVE CARE UNIT		
27	2700 CORONARY CARE UNIT		
28	2800 BURN INTENSIVE CARE UNIT		
29	2900 SURGICAL INTENSIVE CARE UNIT		
31	3100 SUBPROVIDER		
33	3300 NURSERY		
34	3400 SKILLED NURSING FACILITY		
35	3500 NURSING FACILITY		
35.01	3510 ICF/MR		
36	3600 OTHER LONG TERM CARE		
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		629,161
38	3800 RECOVERY ROOM		
39	3900 DELIVERY ROOM & LABOR ROOM		
40	4000 ANESTHESIOLOGY	-334,111	
41	4100 RADIOLOGY-DIAGNOSTIC		909,129
42	4200 RADIOLOGY-THERAPEUTIC		
43	4300 RADIOISOTOPE		
44	4400 LABORATORY		1,110,964
45	4500 PBP CLINICAL LAB SERVICES-PRGM ONLY		
46	4600 WHOLE BLOOD & PACKED RED BLOOD CELLS		
47	4700 BLOOD STORING, PROCESSING & TRANS.		
48	4800 INTRAVENOUS THERAPY		
49	4900 RESPIRATORY THERAPY		154,563
50	5000 PHYSICAL THERAPY		557,592
51	5100 OCCUPATIONAL THERAPY		
52	5200 SPEECH PATHOLOGY		1,744
53	5300 ELECTROCARDIOLOGY		128,118
54	5400 ELECTROENCEPHALOGRAPHY		
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		603,672
55.30	5530 IMPL. DEV. CHARGED TO PATIENT		168,476
56	5600 DRUGS CHARGED TO PATIENTS	-2,199	825,895
57	5700 RENAL DIALYSIS		
58	5800 ASC (NON-DISTINCT PART)		
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC		
61	6100 EMERGENCY		1,373,272
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
	OTHER REIMBURS COST CNTRS		
64	6400 HOME PROGRAM DIALYSIS		
65	6500 AMBULANCE SERVICES		
66	6600 DURABLE MEDICAL EQUIP-RENTED		
67	6700 DURABLE MEDICAL EQUIP-SOLD		
69	6900 CORF		
70	7000 I&R SERVICES-NOT APPRVD PRGM		
71	7100 HOME HEALTH AGENCY		
	SPEC PURPOSE COST CENTERS		
82	8200 LUNG ACQUISITION		
83	8300 KIDNEY ACQUISITION		
84	8400 LIVER ACQUISITION		
85	8500 HEART ACQUISITION		
86	8600 OTHER ORGAN ACQUISITION		
88	8800 INTEREST EXPENSE		-0-
89	8900 UTILIZATION REVIEW-SNF		-0-
90	9000 OTHER CAPITAL RELATED COSTS		-0-
92	9200 AMBULATORY SURGICAL CENTER (D.P.)		
93	9300 HOSPICE		
95	SUBTOTALS	-68,799	17,578,402
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
I 15-1309 I FROM 7/ 1/2009 I WORKSHEET A
I I TO 6/30/2010 I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	NONREIMBURS COST CENTERS		
97	9700 RESEARCH		
98	9800 PHYSICIANS' PRIVATE OFFICES		
98.01	9801 PHYSICIANS' PRIVATE OFFICES		13,984
98.02	9802 CLAY COUNTY - CLINIC		293,409
98.03	9803 MISSION SERVICES		185
98.04	9804 PUBLIC RELATIONS	274,339	296,968
99	9900 NONPAID WORKERS		
100	7950 OTHER NONREIMBURSABLE COST CENTERS		
101	TOTAL	205,540	18,182,948

COST CENTERS USED IN COST REPORT

I PROVIDER NO:	I PERIOD:	I PREPARED 11/30/2010
I 15-1309	I FROM 7/ 1/2009	I NOT A CMS WORKSHEET
I	I TO 6/30/2010	I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
1	OLD CAP REL COSTS-BLDG & FIXT	0100	
2	OLD CAP REL COSTS-MVBLE EQUIP	0200	
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
4.01	NEW CAP REL COSTS-MOB BLD	0401	NEW CAP REL COSTS-MVBLE EQUIP
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
13	MAINTENANCE OF PERSONNEL	1300	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
20	NONPHYSICIAN ANESTHETISTS	2000	
21	NURSING SCHOOL	2100	
22	I&R SERVICES-SALARY & FRINGES APPRVD	2200	
23	I&R SERVICES-OTHER PRGM COSTS APPRVD	2300	
24	PARAMED ED PRGM	2400	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
27	CORONARY CARE UNIT	2700	
28	BURN INTENSIVE CARE UNIT	2800	
29	SURGICAL INTENSIVE CARE UNIT	2900	
31	SUBPROVIDER	3100	
33	NURSEY	3300	
34	SKILLED NURSING FACILITY	3400	
35	NURSING FACILITY	3500	
35.01	ICF/MR	3510	
36	OTHER LONG TERM CARE	3600	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
38	RECOVERY ROOM	3800	
39	DELIVERY ROOM & LABOR ROOM	3900	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
42	RADIOLOGY-THERAPEUTIC	4200	
43	RADIOISOTOPE	4300	
44	LABORATORY	4400	
45	PBP CLINICAL LAB SERVICES-PRGM ONLY	4500	
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	4600	
47	BLOOD STORING, PROCESSING & TRANS.	4700	
48	INTRAVENOUS THERAPY	4800	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
54	ELECTROENCEPHALOGRAPHY	5400	
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	
57	RENAL DIALYSIS	5700	
58	ASC (NON-DISTINCT PART)	5800	
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	OTHER REIMBURS COST		
64	HOME PROGRAM DIALYSIS	6400	
65	AMBULANCE SERVICES	6500	
66	DURABLE MEDICAL EQUIP-RENTED	6600	
67	DURABLE MEDICAL EQUIP-SOLD	6700	
69	CORF	6900	
70	I&R SERVICES-NOT APPRVD PRGM	7000	
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
82	LUNG ACQUISITION	8200	
83	KIDNEY ACQUISITION	8300	
84	LIVER ACQUISITION	8400	
85	HEART ACQUISITION	8500	
86	OTHER ORGAN ACQUISITION	8600	
88	INTEREST EXPENSE	8800	
89	UTILIZATION REVIEW-SNF	8900	
90	OTHER CAPITAL RELATED COSTS	9000	
92	AMBULATORY SURGICAL CENTER (D.P.)	9200	
93	HOSPICE	9300	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	NONREIMBURS COST CEN		
97	RESEARCH	9700	
98	PHYSICIANS' PRIVATE OFFICES	9800	
98.01	PHYSICIANS' PRIVATE OFFICES	9801	PHYSICIANS' PRIVATE OFFICES
98.02	CLAY COUNTY - CLINIC	9802	PHYSICIANS' PRIVATE OFFICES
98.03	MISSION SERVICES	9803	PHYSICIANS' PRIVATE OFFICES
98.04	PUBLIC RELATIONS	9804	PHYSICIANS' PRIVATE OFFICES
99	NONPAID WORKERS	9900	
100	OTHER NONREIMBURSABLE COST CENTERS	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151309	7/ 1/2009	11/30/2010
	TO	WORKSHEET A-6
	6/30/2010	

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1)	COST CENTER	LINE NO	SALARY	OTHER
	1	2	3	4	5
1 NURSING EDUCATION	A	NURSING ADMINISTRATION	14	21,208	
2 INTEREST	B	ADMINISTRATIVE & GENERAL	6		45,367
3		NEW CAP REL COSTS-BLDG & FIXT	3		62,733
4		NEW CAP REL COSTS-MVBLE EQUIP	4		125,958
5 IMPLANTABLE DEVICES	C	IMPL. DEV. CHARGED TO PATIENT	55.30		168,476
6					
7 CAFETERIA	D	CAFETERIA	12	134,512	52,814
8 CLINIC CAPITAL	E	NEW CAP REL COSTS-MVBLE EQUIP	4		49
9 EMPLOYEE ADS	F	ADMINISTRATIVE & GENERAL	6		18,719
10 PROPERTY INSURANCE	G	NEW CAP REL COSTS-BLDG & FIXT	3		5,406
11		NEW CAP REL COSTS-MVBLE EQUIP	4		10,853
12 ROUTINE, OR, AND ER BILL SUPPLIES	H	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		236,554
13		DRUGS CHARGED TO PATIENTS	56		18,837
14		PHARMACY	16		400
15					
16					
17					
18					
19					
36 TOTAL RECLASSIFICATIONS				155,720	746,166

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED 11/30/2010
151309	FROM 7/ 1/2009	WORKSHEET A-6
	TO 6/30/2010	

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE			A-7 REF 10
			LINE NO	SALARY	OTHER	
	1	6	7	8	9	
1 NURSING EDUCATION	A	PUBLIC RELATIONS	98.04	21,208		
2 INTEREST	B	NEW CAP REL COSTS-BLDG & FIXT	3		45,367	11
3		NEW CAP REL COSTS-BLDG & FIXT	3		188,691	11
4						11
5 IMPLANTABLE DEVICES	C	OPERATING ROOM	37		6,498	
6		MEDICAL SUPPLIES CHARGED TO PATIENTS	55		161,978	
7 CAFETERIA	D	DIETARY	11	134,512	52,814	
8 CLINIC CAPITAL	E	CLAY COUNTY - CLINIC	98.02		49	11
9 EMPLOYEE ADS	F	PUBLIC RELATIONS	98.04		18,719	
10 PROPERTY INSURANCE	G	NEW CAP REL COSTS-BLDG & FIXT	3		16,259	11
11						11
12 ROUTINE, OR, AND ER BILL SUPPLIES	H	CENTRAL SERVICES & SUPPLY	15		79	
13		PHARMACY	16		457	
14		ADULTS & PEDIATRICS	25		7,958	
15		OPERATING ROOM	37		140,821	
16		RADIOLOGY-DIAGNOSTIC	41		61,055	
17		RESPIRATORY THERAPY	49		31,271	
18		MEDICAL SUPPLIES CHARGED TO PATIENTS	55		400	
19		EMERGENCY	61		13,750	
36 TOTAL RECLASSIFICATIONS				155,720	746,166	

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151309	7/ 1/2009	11/30/2010
	FROM	WORKSHEET A-6
	TO	6/30/2010
		NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : NURSING EDUCATION

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	NURSING ADMINISTRATION	21,208
TOTAL RECLASSIFICATIONS FOR CODE A		21,208

DECREASE		
COST CENTER	LINE	AMOUNT
PUBLIC RELATIONS	98.04	21,208
TOTAL RECLASSIFICATIONS FOR CODE A		21,208

RECLASS CODE: B
EXPLANATION : INTEREST

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	45,367
2.00	NEW CAP REL COSTS-BLDG & FIXT	62,733
3.00	NEW CAP REL COSTS-MVBLE EQUIP	125,958
TOTAL RECLASSIFICATIONS FOR CODE B		234,058

DECREASE		
COST CENTER	LINE	AMOUNT
NEW CAP REL COSTS-BLDG & FIXT	3	45,367
NEW CAP REL COSTS-BLDG & FIXT	3	188,691
TOTAL RECLASSIFICATIONS FOR CODE B		234,058

RECLASS CODE: C
EXPLANATION : IMPLANTABLE DEVICES

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	IMPL. DEV. CHARGED TO PATIENT	168,476
2.00		0
TOTAL RECLASSIFICATIONS FOR CODE C		168,476

DECREASE		
COST CENTER	LINE	AMOUNT
OPERATING ROOM	37	6,498
MEDICAL SUPPLIES CHARGED TO PA	55	161,978
TOTAL RECLASSIFICATIONS FOR CODE C		168,476

RECLASS CODE: D
EXPLANATION : CAFETERIA

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	CAFETERIA	187,326
TOTAL RECLASSIFICATIONS FOR CODE D		187,326

DECREASE		
COST CENTER	LINE	AMOUNT
DIETARY	11	187,326
TOTAL RECLASSIFICATIONS FOR CODE D		187,326

RECLASS CODE: E
EXPLANATION : CLINIC CAPITAL

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	49
TOTAL RECLASSIFICATIONS FOR CODE E		49

DECREASE		
COST CENTER	LINE	AMOUNT
CLAY COUNTY - CLINIC	98.02	49
TOTAL RECLASSIFICATIONS FOR CODE E		49

RECLASS CODE: F
EXPLANATION : EMPLOYEE ADS

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	18,719
TOTAL RECLASSIFICATIONS FOR CODE F		18,719

DECREASE		
COST CENTER	LINE	AMOUNT
PUBLIC RELATIONS	98.04	18,719
TOTAL RECLASSIFICATIONS FOR CODE F		18,719

RECLASS CODE: G
EXPLANATION : PROPERTY INSURANCE

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	5,406
2.00	NEW CAP REL COSTS-MVBLE EQUIP	10,853
TOTAL RECLASSIFICATIONS FOR CODE G		16,259

DECREASE		
COST CENTER	LINE	AMOUNT
NEW CAP REL COSTS-BLDG & FIXT	3	16,259
TOTAL RECLASSIFICATIONS FOR CODE G		16,259

RECLASS CODE: H
EXPLANATION : ROUTINE, OR, AND ER BILL SUPPLIES

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	236,554
2.00	DRUGS CHARGED TO PATIENTS	18,837
3.00	PHARMACY	400
4.00		0
5.00		0
6.00		0
7.00		0
8.00		0
TOTAL RECLASSIFICATIONS FOR CODE H		255,791

DECREASE		
COST CENTER	LINE	AMOUNT
CENTRAL SERVICES & SUPPLY	15	79
PHARMACY	16	457
ADULTS & PEDIATRICS	25	7,958
OPERATING ROOM	37	140,821
RADIOLOGY-DIAGNOSTIC	41	61,055
RESPIRATORY THERAPY	49	31,271
MEDICAL SUPPLIES CHARGED TO PA	55	400
EMERGENCY	61	13,750
TOTAL RECLASSIFICATIONS FOR CODE H		255,791

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
				DONATION 3					
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 BALANCES 1	PURCHASES 2	ACQUISITIONS		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
				DONATION 3					
1	LAND	2,500						2,500	
2	LAND IMPROVEMENTS	317,947						317,947	
3	BUILDINGS & FIXTURE	8,844,102						8,844,102	
4	BUILDING IMPROVEMEN								
5	FIXED EQUIPMENT	8,754,765	58,637			58,637		8,813,402	
6	MOVABLE EQUIPMENT								
7	SUBTOTAL	17,919,314	58,637			58,637		17,977,951	
8	RECONCILING ITEMS								
9	TOTAL	17,919,314	58,637			58,637		17,977,951	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	GROSS ASSETS 1	COMPUTATION OF RATIOS CAPITIALIZED GROSS ASSETS		RATIO 4	ALLOCATION OF OTHER CAPITAL			TOTAL 8
			LEASES 2	FOR 3		INSURANCE 5	TAXES 6	OTHER CAPITAL RELATED COSTS 7	
1	OLD CAP REL COSTS-BL								
2	OLD CAP REL COSTS-MV								
3	NEW CAP REL COSTS-BL	9,164,549		9,164,549	.509766				
4	NEW CAP REL COSTS-MV	8,813,402		8,813,402	.490234				
4 01	NEW CAP REL COSTS-MO								
5	TOTAL	17,977,951		17,977,951	1.000000				

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	624,284		-182,178				442,106
4	NEW CAP REL COSTS-MV	927,471		136,860				1,064,331
4 01	NEW CAP REL COSTS-MO	351,540						351,540
5	TOTAL	1,903,295		-45,318				1,857,977

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	450,268						450,268
4	NEW CAP REL COSTS-MV	1,053,429						1,053,429
4 01	NEW CAP REL COSTS-MO	351,540						351,540
5	TOTAL	1,855,237						1,855,237

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: I 15-1309
I

I PERIOD: I PREPARED 11/30/2010
I FROM 7/ 1/2009 I WORKSHEET A-8
I TO 6/30/2010 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 COST CENTER	4	5
1			OLD CAP REL COSTS-BLDG &	1	
2			OLD CAP REL COSTS-MVBLE E	2	
3	B	-43,620	NEW CAP REL COSTS-BLDG &	3	9
4	B	-87,583	NEW CAP REL COSTS-MVBLE E	4	9
5					
6					
7					
8					
9	A	-9,000	ADMINISTRATIVE & GENERAL	6	
10	A	-2,168	OPERATION OF PLANT	8	
11					
12	A-8-2				
13					
14	A-8-1	754,946			
15					
16	B	-40,937	CAFETERIA	12	
17					
18					
19	B	-2,199	DRUGS CHARGED TO PATIENTS	56	
20					
21					
22					
23					
24					
25	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	A-8-3				
28			UTILIZATION REVIEW-SNF	89	
29			OLD CAP REL COSTS-BLDG &	1	
30			OLD CAP REL COSTS-MVBLE E	2	
31			NEW CAP REL COSTS-BLDG &	3	
32			NEW CAP REL COSTS-MVBLE E	4	
33			NONPHYSICIAN ANESTHETISTS	20	
34					
35	A-8-4		OCCUPATIONAL THERAPY	51	
36	A-8-4		SPEECH PATHOLOGY	52	
37	B	-22,117	ADMINISTRATIVE & GENERAL	6	
38	A	-810	ADMINISTRATIVE & GENERAL	6	
39	A	-334,111	ANESTHESIOLOGY	40	
40	A	40,059	ADMINISTRATIVE & GENERAL	6	
41	B	-31,545	ADMINISTRATIVE & GENERAL	6	
42	A	-921	ADMINISTRATIVE & GENERAL	6	
43	A	-906	ADMINISTRATIVE & GENERAL	6	
44	A	-13,548	ADMINISTRATIVE & GENERAL	6	
45					
46					
47					
48					
49					
50		205,540			

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

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	3	NEW CAP REL COSTS-BLDG & HOME OFFICE	236,749		236,749	9
2	6	ADMINISTRATIVE & GENERAL HOME OFFICE	1,518,629	1,071,739	446,890	9
3	5	EMPLOYEE BENEFITS ST. VINCENT HOSPITAL - IN	198,288	198,288		
4	6	ADMINISTRATIVE & GENERAL ST. VINCENT HOSPITAL - IN	583,435	583,435		
4.01	5	EMPLOYEE BENEFITS ASCENSION CHARGEBACK	160,800	160,800		
4.02	3	NEW CAP REL COSTS-BLDG & ASCENSION CHARGEBACK	250,317	250,317		9
4.03	6	ADMINISTRATIVE & GENERAL ASCENSION CHARGEBACK	76,292	76,292		
4.04	3	NEW CAP REL COSTS-BLDG & ASCENSION INTEREST	43,620	62,733	-19,113	9
4.05	6	ADMINISTRATIVE & GENERAL ASCENSION INTEREST	31,545	45,367	-13,822	9
4.06	6	ADMINISTRATIVE & GENERAL ASCENSION - MAINTENANCE	9,648	10,434	-786	
4.07	41	RADIOLOGY-DIAGNOSTIC ST. VINCENT HOSPITAL - IN	10,750	10,750		
4.08	98 2	CLAY COUNTY - CLINIC ST. VINCENT HOSPITAL - IN	14,545	14,545		
4.09	4	NEW CAP REL COSTS-MVBLE E ASCENSION INTEREST	87,583	125,958	-38,375	9
4.10	5	EMPLOYEE BENEFITS SELF INSURANCE	606,393	737,329	-130,936	
4.11	17	MEDICAL RECORDS & LIBRARY ST. VINCENT HOSPITAL - IN	50,689	50,689		
4.12	37	OPERATING ROOM ST. VINCENT HOSPITAL - IN	5,975	5,975		
4.13	5	EMPLOYEE BENEFITS PENSION	296,857	296,857		
4.14	98 4	PUBLIC RELATIONS ST. VINCENT HOSPITAL - IN	303	303		
4.15	98 4	PUBLIC RELATIONS MARKETING	274,339		274,339	
4.16	8	OPERATION OF PLANT ST. VINCENT HOSPITAL - IN	195	195		
4.17	61	EMERGENCY ST. VINCENT HOSPITAL - IN	11,175	11,175		
5		TOTALS	4,468,127	3,713,181	754,946	

* 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	ST. VINCENT HEALTH	100.00	ST. VINCENT HEALTH	100.00	ADMINISTRATION
2	B	ST. VINCENT HOSPITAL	100.00	ST. VINCENT HOSPITAL	100.00	HOSPITAL
3	G	ASCENSION	100.00	ASCENSION	100.00	ADMINISTRATION
4			0.00		0.00	
5			0.00		0.00	

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I
I 15-1309
I

I PERIOD: I
I FROM 7/ 1/2009 I
I TO 6/30/2010 I

I PREPARED 11/30/2010
I WORKSHEET A-8-2
I GROUP 1

	WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
	1	2	3	4	5	6	7	8	9
1	44	LABORATORY	27,500		27,500				
2	61	EMERGENCY	560,051		560,051				
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL	587,551		587,551				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO:
I 15-1309
I

I PERIOD:
I FROM 7/ 1/2009
I TO 6/30/2010

I PREPARED 11/30/2010
I WORKSHEET A-8-2
I GROUP 1

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

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

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET A-8-4
 I I TO 6/30/2010 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)	558
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	19
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	5.61
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5
9	TOTAL HOURS WORKED	1586.00	3769.00	3928.00	4685.00
10	AHSEA (SEE INSTRUCTIONS)	81.41	70.79	53.09	47.19
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	35.40	35.40	26.55	
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	129,116
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	266,808
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	208,538
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	604,462
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	221,085
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)	825,547

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)	825,547

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)	19,753
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	504
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	20,257
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	3,237
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	23,494
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	

PHYSICAL THERAPY

33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 23,494
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 825,547
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 23,494
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)
 60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)
 61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)
 63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 849,041
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 549,120

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 - 549,120
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS
 LINE MUST AGREE WITH LINE 64) 549,120
 68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO 1.000000
 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)
 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 11/30/2010
I 15-1309 I FROM 7/ 1/2009 I WORKSHEET A-8-4
I I TO 6/30/2010 I PARTS I - VII

SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	14
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	210
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	18
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	5.61
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5
9	TOTAL HOURS WORKED				
10	AHSEA (SEE INSTRUCTIONS)		33.00		
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	32.25	32.25		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	2,129
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)	2,129
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)	2,129

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)	64.52
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	13,549
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	13,549

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)	581
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	581
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	101
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	682
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
32	OPTIONAL TRAVEL EXPENSE (LN 8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	

SPEECH PATHOLOGY

33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 682
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 13,549
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 682
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)
 60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)
 61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)
 63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 14,231
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 1,625

SPEECH PATHOLOGY

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 - 1,625
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS
 LINE MUST AGREE WITH LINE 64) 1,625
 68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO 1.000000
 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)
 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 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I NOT A CMS WORKSHEET
 I I TO 6/30/2010 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
1	OLD CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEET	NOT ENTERED
2	OLD CAP REL COSTS-MVBLE EQUIP	2	DOLLAR	VALUE	NOT ENTERED
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	4	SQUARE	FEET	ENTERED
4.01	NEW CAP REL COSTS-MOB BLD	19	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	6	SQUARE	FEET	NOT ENTERED
8	OPERATION OF PLANT	7	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	9	HOURS OF	SERVICE	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	11	MEALS	SERVED	ENTERED
13	MAINTENANCE OF PERSONNEL	12	NUMBER	HOUSED	NOT ENTERED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED	REQUIS.	ENTERED
16	PHARMACY	15	COSTED	REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME	SPENT	ENTERED
18	SOCIAL SERVICE	17	TIME	SPENT	NOT ENTERED
20	NONPHYSICIAN ANESTHETISTS	18	ASSIGNED	TIME	NOT ENTERED
21	NURSING SCHOOL	20	ASSIGNED	TIME	NOT ENTERED
22	I&R SERVICES-SALARY & FRINGES APPRVD	20	ASSIGNED	TIME	NOT ENTERED
23	I&R SERVICES-OTHER PRGM COSTS APPRVD	21	ASSIGNED	TIME	NOT ENTERED
24	PARAMED ED PRGM	19	SQUARE	FEET	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	OLD CAP REL OSTS-BLDG &	C OLD CAP REL OSTS-MVBLE	C NEW CAP REL OSTS-BLDG &	C NEW CAP REL OSTS-MVBLE	C NEW CAP REL OSTS-MOB BLD	C EMPLOYEE BENE FITS
	0	1	2	3	4	4.01	5
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &	442,106			442,106			
004 NEW CAP REL COSTS-MVBLE E	1,064,331				1,064,331		
01 004 NEW CAP REL COSTS-MOB BLD	351,540					351,540	
005 EMPLOYEE BENEFITS	2,153,047						2,153,047
006 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	3,598,289			146,832	345,967	17,524	533,349
007 OPERATION OF PLANT	727,274			90,728	213,776		99,334
009 LAUNDRY & LINEN SERVICE	77,354			9,483	22,344		
010 HOUSEKEEPING	277,498			5,259	12,391		71,946
011 DIETARY	164,461			11,681	27,522		38,999
012 CAFETERIA	146,389			6,626	15,612		44,422
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION	219,732			1,447	3,410		66,672
015 CENTRAL SERVICES & SUPPLY	111,071			8,025	18,908		
016 PHARMACY	400,602			5,189	12,227		
017 MEDICAL RECORDS & LIBRARY	315,670			46,005	108,397		98,810
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	1,066,452			29,864	70,366		331,083
026 INTENSIVE CARE UNIT							
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
031 SUBPROVIDER							
033 NURSERY							
034 SKILLED NURSING FACILITY							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM	629,161			12,260	28,887		164,993
039 RECOVERY ROOM							
040 DELIVERY ROOM & LABOR ROO							
041 ANESTHESIOLOGY							
042 RADIOLOGY-DIAGNOSTIC	909,129			8,502	20,032		195,003
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
044 LABORATORY	1,110,964			6,953	16,382	14,005	124,201
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	154,563			8,384	19,755		46,063
050 PHYSICAL THERAPY	557,592			8,904	20,980	41,346	
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY	1,744						
053 ELECTROCARDIOLOGY	128,118						38,075
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED	603,672						
30 055 IMPL. DEV. CHARGED TO PAT	168,476						
056 DRUGS CHARGED TO PATIENTS	825,895						
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
061 EMERGENCY	1,373,272			24,600	57,963		232,482
062 OBSERVATION BEDS (NON-DIS							
062 OTHER REIMBURS COST CNTRS							
064 HOME PROGRAM DIALYSIS							
065 AMBULANCE SERVICES							
066 DURABLE MEDICAL EQUIP-REN							
067 DURABLE MEDICAL EQUIP-SOL							
069 CORF							
070 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
083 SPEC PURPOSE COST CENTERS							
083 KIDNEY ACQUISITION							
084 LIVER ACQUISITION							
085 HEART ACQUISITION							
086 OTHER ORGAN ACQUISITION							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	17,578,402			430,742	1,014,919	72,875	2,085,432
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP				1,136	2,678		
097 RESEARCH							

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	0	1	2	3	4	4.01	5
098 NONREIMBURS COST CENTERS								
098 PHYSICIANS' PRIVATE OFFIC								
098 01 PHYSICIANS' PRIVATE OFFIC	13,984							
098 02 CLAY COUNTY - CLINIC	293,409					22,634	278,665	60,611
098 03 MISSION SERVICES	185							
098 04 PUBLIC RELATIONS	296,968				268	632		7,004
099 NONPAID WORKERS								
100 OTHER NONREIMBURSABLE COS					9,960	23,468		
101 CROSS FOOT ADJUSTMENT								
102 NEGATIVE COST CENTER								
103 TOTAL	18,182,948				442,106	1,064,331	351,540	2,153,047

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART I

COST CENTER DESCRIPTION		SUBTOTAL	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5a.00	6	7	8	9	10	11
	GENERAL SERVICE COST CNTR							
001	OLD CAP REL COSTS-BLDG &							
002	OLD CAP REL COSTS-MVBLE E							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
004	01 NEW CAP REL COSTS-MOB BLD							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL	4,641,961	4,641,961					
007	MAINTENANCE & REPAIRS							
008	OPERATION OF PLANT	1,131,112	387,754		1,518,866			
009	LAUNDRY & LINEN SERVICE	109,181	37,428		63,909	210,518		
010	HOUSEKEEPING	367,094	125,843		35,441	6,482	534,860	
011	DIETARY	242,663	83,187		78,721	3,020	17,025	424,616
012	CAFETERIA	213,049	73,035		44,653		3,547	
013	MAINTENANCE OF PERSONNEL							
014	NURSING ADMINISTRATION	291,261	99,847		9,754		24,828	
015	CENTRAL SERVICES & SUPPLY	138,004	47,309		54,083			
016	PHARMACY	418,018	143,300		34,971			
017	MEDICAL RECORDS & LIBRARY	568,882	195,017		310,048		6,384	
018	SOCIAL SERVICE							
020	NONPHYSICIAN ANESTHETISTS							
021	NURSING SCHOOL							
022	I&R SERVICES-SALARY & FRI							
023	I&R SERVICES-OTHER PRGM C							
024	PARAMED ED PRGM							
025	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	1,497,765	513,446		201,265	71,672	158,897	424,616
026	INTENSIVE CARE UNIT							
027	CORONARY CARE UNIT							
028	BURN INTENSIVE CARE UNIT							
029	SURGICAL INTENSIVE CARE U							
031	SUBPROVIDER							
033	NURSERY							
034	SKILLED NURSING FACILITY							
035	NURSING FACILITY							
035	01 ICF/MR							
036	OTHER LONG TERM CARE							
037	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	835,301	286,348		82,623	33,493	48,946	
038	RECOVERY ROOM							
039	DELIVERY ROOM & LABOR ROO							
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC	1,132,666	388,287		57,298	25,896	28,375	
042	RADIOLOGY-THERAPEUTIC							
043	RADIOISOTOPE							
044	LABORATORY	1,272,505	436,225		82,370		39,015	
045	PBP CLINICAL LAB SERVICES							
046	WHOLE BLOOD & PACKED RED							
047	BLOOD STORING, PROCESSING							
048	INTRAVENOUS THERAPY							
049	RESPIRATORY THERAPY	228,765	78,422		56,503			
050	PHYSICAL THERAPY	628,822	215,565		164,849	4,766	42,562	
051	OCCUPATIONAL THERAPY							
052	SPEECH PATHOLOGY	1,744	598					
053	ELECTROCARDIOLOGY	166,193	56,972				14,187	
054	ELECTROENCEPHALOGRAPHY							
055	MEDICAL SUPPLIES CHARGED	603,672	206,944					
055	30 IMPL. DEV. CHARGED TO PAT	168,476	57,755					
056	DRUGS CHARGED TO PATIENTS	825,895	283,123				10,640	
057	RENAL DIALYSIS							
058	ASC (NON-DISTINCT PART)							
060	OUTPAT SERVICE COST CNTRS							
060	CLINIC							
061	EMERGENCY	1,688,317	578,772		165,788	65,189	140,454	
062	OBSERVATION BEDS (NON-DIS							
062	OTHER REIMBURS COST CNTRS							
064	HOME PROGRAM DIALYSIS							
065	AMBULANCE SERVICES							
066	DURABLE MEDICAL EQUIP-REN							
067	DURABLE MEDICAL EQUIP-SOL							
069	CORF							
070	I&R SERVICES-NOT APPRVD P							
071	HOME HEALTH AGENCY							
082	LUNG ACQUISITION							
083	SPEC PURPOSE COST CENTERS							
083	KIDNEY ACQUISITION							
084	LIVER ACQUISITION							
085	HEART ACQUISITION							
086	OTHER ORGAN ACQUISITION							
092	AMBULATORY SURGICAL CENTE							
093	HOSPICE							
095	SUBTOTALS	17,171,346	4,295,177		1,442,276	210,518	534,860	424,616
096	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP	3,814	1,307		7,659			
097	RESEARCH							

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	SUBTOTAL	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
	5a.00	6	7	8	9	10	11
NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC							
098 01 PHYSICIANS' PRIVATE OFFIC	292,649	100,322					
098 02 CLAY COUNTY - CLINIC	376,654	129,120					
098 03 MISSION SERVICES	185	63					
098 04 PUBLIC RELATIONS	304,872	104,513		1,806			
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS	33,428	11,459		67,125			
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	18,182,948	4,641,961		1,518,866	210,518	534,860	424,616

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B
 I TO 6/30/2010 I PART I

COST CENTER DESCRIPTION	CAFETERIA	MAINTENANCE O F PERSONNEL	NURSING ADMIN ISTRATION	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E
	12	13	14	15	16	17	18
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
004 01 NEW CAP REL COSTS-MVBLE E							
005 NEW CAP REL COSTS-MOB BLD							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE							
011 HOUSEKEEPING							
012 DIETARY							
012 CAFETERIA	334,284						
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION	17,063		442,753				
015 CENTRAL SERVICES & SUPPLY				239,396			
016 PHARMACY					596,289		
017 MEDICAL RECORDS & LIBRARY	26,419					1,106,750	
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	88,460		206,851			46,815	
027 INTENSIVE CARE UNIT							
028 CORONARY CARE UNIT							
029 BURN INTENSIVE CARE UNIT							
031 SURGICAL INTENSIVE CARE U							
033 SUBPROVIDER							
034 NURSERY							
034 SKILLED NURSING FACILITY							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	47,585		111,271			128,391	
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	43,981					297,216	
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY	34,203					214,702	
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	12,385					19,531	
050 PHYSICAL THERAPY						41,219	
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY							104
053 ELECTROCARDIOLOGY	8,934					43,381	
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED					239,396	35,714	
055 30 IMPL. DEV. CHARGED TO PAT						31,921	
056 DRUGS CHARGED TO PATIENTS						88,029	
057 RENAL DIALYSIS					596,289		
058 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
061 EMERGENCY	53,298		124,631			159,727	
062 OBSERVATION BEDS (NON-DIS							
062 OTHER REIMBURS COST CNTRS							
064 HOME PROGRAM DIALYSIS							
065 AMBULANCE SERVICES							
066 DURABLE MEDICAL EQUIP-REN							
067 DURABLE MEDICAL EQUIP-SOL							
069 CORF							
070 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
083 SPEC PURPOSE COST CENTERS							
084 KIDNEY ACQUISITION							
085 LIVER ACQUISITION							
086 HEART ACQUISITION							
086 OTHER ORGAN ACQUISITION							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	332,328		442,753	239,396	596,289	1,106,750	
096 NONREIMBURS COST CENTERS							
097 GIFT, FLOWER, COFFEE SHOP							
097 RESEARCH							

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	CAFETERIA 12	MAINTENANCE O F PERSONNEL 13	NURSING ADMIN ISTRATION 14	CENTRAL SERVI CES & SUPPLY 15	PHARMACY 16	MEDICAL RECOR DS & LIBRARY 17	SOCIAL SERVIC E 18
NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC							
098 01 PHYSICIANS' PRIVATE OFFIC							
098 02 CLAY COUNTY - CLINIC							
098 03 MISSION SERVICES							
098 04 PUBLIC RELATIONS	1,956						
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	334,284		442,753	239,396	596,289	1,106,750	

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART I

COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	I&R SERVICES- SALARY & FRI	I&R SERVICES- OTHER PRGM C	PARAMED ED PRGM	ED PR	SUBTOTAL	I&R COST POST STEP-DOWN ADJ
	20	21	22	23	24		25	26
001 GENERAL SERVICE COST CNTR								
002 OLD CAP REL COSTS-BLDG &								
003 OLD CAP REL COSTS-MVBLE E								
004 NEW CAP REL COSTS-BLDG &								
004 01 NEW CAP REL COSTS-MVBLE E								
004 01 NEW CAP REL COSTS-MOB BLD								
005 EMPLOYEE BENEFITS								
006 ADMINISTRATIVE & GENERAL								
007 MAINTENANCE & REPAIRS								
008 OPERATION OF PLANT								
009 LAUNDRY & LINEN SERVICE								
010 HOUSEKEEPING								
011 DIETARY								
012 CAFETERIA								
013 MAINTENANCE OF PERSONNEL								
014 NURSING ADMINISTRATION								
015 CENTRAL SERVICES & SUPPLY								
016 PHARMACY								
017 MEDICAL RECORDS & LIBRARY								
018 SOCIAL SERVICE								
020 NONPHYSICIAN ANESTHETISTS								
021 NURSING SCHOOL								
022 I&R SERVICES-SALARY & FRI								
023 I&R SERVICES-OTHER PRGM C								
024 PARAMED ED PRGM								
025 INPAT ROUTINE SRVC CNTRS								
025 ADULTS & PEDIATRICS							3,209,787	
026 INTENSIVE CARE UNIT								
027 CORONARY CARE UNIT								
028 BURN INTENSIVE CARE UNIT								
029 SURGICAL INTENSIVE CARE U								
031 SUBPROVIDER								
033 NURSERY								
034 SKILLED NURSING FACILITY								
035 NURSING FACILITY								
035 01 ICF/MR								
036 OTHER LONG TERM CARE								
037 ANCILLARY SRVC COST CNTRS								
037 OPERATING ROOM							1,573,958	
038 RECOVERY ROOM								
039 DELIVERY ROOM & LABOR ROO								
040 ANESTHESIOLOGY								
041 RADIOLOGY-DIAGNOSTIC							1,973,719	
042 RADIOLOGY-THERAPEUTIC								
043 RADIOISOTOPE								
044 LABORATORY							2,079,020	
045 PBP CLINICAL LAB SERVICES								
046 WHOLE BLOOD & PACKED RED								
047 BLOOD STORING, PROCESSING								
048 INTRAVENOUS THERAPY								
049 RESPIRATORY THERAPY							395,606	
050 PHYSICAL THERAPY							1,097,783	
051 OCCUPATIONAL THERAPY								
052 SPEECH PATHOLOGY							2,446	
053 ELECTROCARDIOLOGY							289,667	
054 ELECTROENCEPHALOGRAPHY								
055 MEDICAL SUPPLIES CHARGED							1,085,726	
055 30 IMPL. DEV. CHARGED TO PAT							258,152	
056 DRUGS CHARGED TO PATIENTS							1,803,976	
057 RENAL DIALYSIS								
058 ASC (NON-DISTINCT PART)								
060 OUTPAT SERVICE COST CNTRS								
060 CLINIC								
061 EMERGENCY							2,976,176	
062 OBSERVATION BEDS (NON-DIS								
062 OTHER REIMBURS COST CNTRS								
064 HOME PROGRAM DIALYSIS								
065 AMBULANCE SERVICES								
066 DURABLE MEDICAL EQUIP-REN								
067 DURABLE MEDICAL EQUIP-SOL								
069 CORF								
070 I&R SERVICES-NOT APPRVD P								
071 HOME HEALTH AGENCY								
082 LUNG ACQUISITION								
082 SPEC PURPOSE COST CENTERS								
083 KIDNEY ACQUISITION								
084 LIVER ACQUISITION								
085 HEART ACQUISITION								
086 OTHER ORGAN ACQUISITION								
092 AMBULATORY SURGICAL CENTE								
093 HOSPICE								
095 SUBTOTALS							16,746,016	
095 NONREIMBURS COST CENTERS								
096 GIFT, FLOWER, COFFEE SHOP							12,780	
097 RESEARCH								

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	I&R SERVICES- SALARY & FRI	I&R SERVICES- OTHER PRGM C	PARAMED ED PR GM	SUBTOTAL	I&R COST POST STEP-DOWN ADJ
	20	21	22	23	24	25	26
NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC						392,971	
098 01 PHYSICIANS' PRIVATE OFFIC						505,774	
098 02 CLAY COUNTY - CLINIC						248	
098 03 MISSION SERVICES						413,147	
098 04 PUBLIC RELATIONS							
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS						112,012	
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL						18,182,948	

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010:
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B
 I TO 6/30/2010 I PART I

COST CENTER DESCRIPTION		TOTAL
		27
001	GENERAL SERVICE COST CNTR	
002	OLD CAP REL COSTS-BLDG &	
003	OLD CAP REL COSTS-MVBLE E	
004	NEW CAP REL COSTS-BLDG &	
004	NEW CAP REL COSTS-MVBLE E	
004	01 NEW CAP REL COSTS-MOB BLD	
005	EMPLOYEE BENEFITS	
006	ADMINISTRATIVE & GENERAL	
007	MAINTENANCE & REPAIRS	
008	OPERATION OF PLANT	
009	LAUNDRY & LINEN SERVICE	
010	HOUSEKEEPING	
011	DIETARY	
012	CAFETERIA	
013	MAINTENANCE OF PERSONNEL	
014	NURSING ADMINISTRATION	
015	CENTRAL SERVICES & SUPPLY	
016	PHARMACY	
017	MEDICAL RECORDS & LIBRARY	
018	SOCIAL SERVICE	
020	NONPHYSICIAN ANESTHETISTS	
021	NURSING SCHOOL	
022	I&R SERVICES-SALARY & FRI	
023	I&R SERVICES-OTHER PRGM C	
024	PARAMED ED PRGM	
025	INPAT ROUTINE SRVC CNTRS	3,209,787
026	ADULTS & PEDIATRICS	
027	INTENSIVE CARE UNIT	
028	CORONARY CARE UNIT	
029	BURN INTENSIVE CARE UNIT	
031	SURGICAL INTENSIVE CARE U	
031	SUBPROVIDER	
033	NURSERY	
034	SKILLED NURSING FACILITY	
035	NURSING FACILITY	
035	01 ICF/MR	
036	OTHER LONG TERM CARE	
037	ANCILLARY SRVC COST CNTRS	
038	OPERATING ROOM	1,573,958
038	RECOVERY ROOM	
039	DELIVERY ROOM & LABOR ROO	
040	ANESTHESIOLOGY	
041	RADIOLOGY-DIAGNOSTIC	1,973,719
042	RADIOLOGY-THERAPEUTIC	
043	RADIOISOTOPE	
044	LABORATORY	2,079,020
045	PBP CLINICAL LAB SERVICES	
046	WHOLE BLOOD & PACKED RED	
047	BLOOD STORING, PROCESSING	
048	INTRAVENOUS THERAPY	
049	RESPIRATORY THERAPY	395,606
050	PHYSICAL THERAPY	1,097,783
051	OCCUPATIONAL THERAPY	
052	SPEECH PATHOLOGY	2,446
053	ELECTROCARDIOLOGY	289,667
054	ELECTROENCEPHALOGRAPHY	
055	MEDICAL SUPPLIES CHARGED	1,085,726
055	30 IMPL. DEV. CHARGED TO PAT	258,152
056	DRUGS CHARGED TO PATIENTS	1,803,976
057	RENAL DIALYSIS	
058	ASC (NON-DISTINCT PART)	
060	OUTPAT SERVICE COST CNTRS	
061	CLINIC	
061	EMERGENCY	2,976,176
062	OBSERVATION BEDS (NON-DIS	
062	OTHER REIMBURS COST CNTRS	
064	HOME PROGRAM DIALYSIS	
065	AMBULANCE SERVICES	
066	DURABLE MEDICAL EQUIP-REN	
067	DURABLE MEDICAL EQUIP-SOL	
069	CORF	
070	I&R SERVICES-NOT APPRVD P	
071	HOME HEALTH AGENCY	
082	LUNG ACQUISITION	
083	SPEC PURPOSE COST CENTERS	
083	KIDNEY ACQUISITION	
084	LIVER ACQUISITION	
085	HEART ACQUISITION	
086	OTHER ORGAN ACQUISITION	
092	AMBULATORY SURGICAL CENTE	
093	HOSPICE	
095	SUBTOTALS	16,746,016
096	NONREIMBURS COST CENTERS	
096	GIFT, FLOWER, COFFEE SHOP	12,780
097	RESEARCH	

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART I

COST CENTER DESCRIPTION		TOTAL
NONREIMBURS COST CENTERS		27
098	PHYSICIANS' PRIVATE OFFIC	
098 01	PHYSICIANS' PRIVATE OFFIC	392,971
098 02	CLAY COUNTY - CLINIC	505,774
098 03	MISSION SERVICES	248
098 04	PUBLIC RELATIONS	413,147
099	NONPAID WORKERS	
100	OTHER NONREIMBURSABLE COS	112,012
101	CROSS FOOT ADJUSTMENT	
102	NEGATIVE COST CENTER	
103	TOTAL	18,182,948

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART III

COST CENTER DESCRIPTION	DIR ASSIGNED NEW CAPITAL REL COSTS	OLD CAP REL C OSTS-BLDG &	OLD CAP REL C OSTS-MVBLE E	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	NEW CAP REL C OSTS-MOB BLD	SUBTOTAL
	0	1	2	3	4	4.01	4a
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
004 01 NEW CAP REL COSTS-MVBLE E							
004 01 NEW CAP REL COSTS-MOB BLD							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL				146,832	345,967	17,524	510,323
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT				90,728	213,776		304,504
009 LAUNDRY & LINEN SERVICE				9,483	22,344		31,827
010 HOUSEKEEPING				5,259	12,391		17,650
011 DIETARY				11,681	27,522		39,203
012 CAFETERIA				6,626	15,612		22,238
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION				1,447	3,410		4,857
015 CENTRAL SERVICES & SUPPLY				8,025	18,908		26,933
016 PHARMACY				5,189	12,227		17,416
017 MEDICAL RECORDS & LIBRARY				46,005	108,397		154,402
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS				29,864	70,366		100,230
026 INTENSIVE CARE UNIT							
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
031 SUBPROVIDER							
033 NURSERY							
034 SKILLED NURSING FACILITY							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM				12,260	28,887		41,147
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC				8,502	20,032		28,534
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY				6,953	16,382	14,005	37,340
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY				8,384	19,755		28,139
050 PHYSICAL THERAPY				8,904	20,980	41,346	71,230
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY							
053 ELECTROCARDIOLOGY							
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED							
055 30 IMPL. DEV. CHARGED TO PAT							
056 DRUGS CHARGED TO PATIENTS							
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC							
061 EMERGENCY				24,600	57,963		82,563
062 OBSERVATION BEDS (NON-DIS							
062 OTHER REIMBURS COST CNTRS							
064 HOME PROGRAM DIALYSIS							
065 AMBULANCE SERVICES							
066 DURABLE MEDICAL EQUIP-REN							
067 DURABLE MEDICAL EQUIP-SOL							
069 CORF							
070 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
083 SPEC PURPOSE COST CENTERS							
083 KIDNEY ACQUISITION							
084 LIVER ACQUISITION							
085 HEART ACQUISITION							
086 OTHER ORGAN ACQUISITION							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS				430,742	1,014,919	72,875	1,518,536
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP				1,136	2,678		3,814
097 RESEARCH							

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	0	1	2	3	4	4.01	4a
098 NONREIMBURS COST CENTERS								
098 PHYSICIANS' PRIVATE OFFIC								
098 01 PHYSICIANS' PRIVATE OFFIC							278,665	278,665
098 02 CLAY COUNTY - CLINIC						22,634		22,634
098 03 MISSION SERVICES								
098 04 PUBLIC RELATIONS					268	632		900
099 NONPAID WORKERS								
100 OTHER NONREIMBURSABLE COS					9,960	23,468		33,428
101 CROSS FOOT ADJUSTMENTS								
102 NEGATIVE COST CENTER								
103 TOTAL					442,106	1,064,331	351,540	1,857,977

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART III

COST CENTER DESCRIPTION	EMPLOYEE BENE FITS	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY
	5	6	7	8	9	10	11
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
004 01 NEW CAP REL COSTS-MVBLE E							
004 01 NEW CAP REL COSTS-MOB BLD							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL		510,323					
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT		42,628		347,132			
009 LAUNDRY & LINEN SERVICE		4,115		14,606	50,548		
010 HOUSEKEEPING		13,835		8,100	1,557	41,142	
011 DIETARY		9,145		17,992	725	1,310	68,375
012 CAFETERIA		8,029		10,205		273	
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION		10,977		2,229		1,910	
015 CENTRAL SERVICES & SUPPLY		5,201		12,360			
016 PHARMACY		15,754		7,993			
017 MEDICAL RECORDS & LIBRARY		21,439		70,861		491	
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS		56,446		45,999	17,209	12,222	68,375
026 INTENSIVE CARE UNIT							
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
031 SUBPROVIDER							
033 NURSERY							
034 SKILLED NURSING FACILITY							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		31,480		18,883	8,042	3,765	
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC		42,687		13,095	6,218	2,183	
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY		47,957		18,825		3,001	
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY		8,621		12,914			
050 PHYSICAL THERAPY		23,698		37,676	1,144	3,274	
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY		66					
053 ELECTROCARDIOLOGY		6,263				1,091	
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED		22,751					
055 30 IMPL. DEV. CHARGED TO PAT		6,349					
056 DRUGS CHARGED TO PATIENTS		31,126				818	
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC							
061 EMERGENCY		63,631		37,890	15,653	10,804	
062 OBSERVATION BEDS (NON-DIS							
062 OTHER REIMBURS COST CNTRS							
064 HOME PROGRAM DIALYSIS							
065 AMBULANCE SERVICES							
066 DURABLE MEDICAL EQUIP-REN							
067 DURABLE MEDICAL EQUIP-SOL							
069 CORF							
070 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
083 SPEC PURPOSE COST CENTERS							
083 KIDNEY ACQUISITION							
084 LIVER ACQUISITION							
085 HEART ACQUISITION							
086 OTHER ORGAN ACQUISITION							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS		472,198		329,628	50,548	41,142	68,375
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP		144		1,750			
097 RESEARCH							

COST CENTER DESCRIPTION		EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5	6	7	8	9	10	11
098	NONREIMBURS COST CENTERS							
098	01 PHYSICIANS' PRIVATE OFFIC		11,029					
098	02 CLAY COUNTY - CLINIC		14,195					
098	03 MISSION SERVICES		7					
098	04 PUBLIC RELATIONS		11,490		413			
099	NONPAID WORKERS							
100	OTHER NONREIMBURSABLE COS		1,260		15,341			
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL		510,323		347,132	50,548	41,142	68,375

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART III

COST CENTER DESCRIPTION	CAFETERIA	MAINTENANCE O F PERSONNEL	NURSING ADMIN ISTRATION	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E
	12	13	14	15	16	17	18
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
004 01 NEW CAP REL COSTS-MVBLE E							
005 NEW CAP REL COSTS-MOB BLD							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE							
011 HOUSEKEEPING							
012 DIETARY							
012 CAFETERIA	40,745						
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION	2,080		22,053				
015 CENTRAL SERVICES & SUPPLY				44,494			
016 PHARMACY					41,163		
017 MEDICAL RECORDS & LIBRARY	3,220					250,413	
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	10,782		10,303			10,592	
027 INTENSIVE CARE UNIT							
028 CORONARY CARE UNIT							
029 BURN INTENSIVE CARE UNIT							
031 SURGICAL INTENSIVE CARE U							
033 SUBPROVIDER							
034 NURSERY							
034 SKILLED NURSING FACILITY							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	5,800		5,542			29,048	
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	5,361					67,259	
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY	4,169					48,575	
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	1,510					4,419	
050 PHYSICAL THERAPY						9,326	
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY							24
053 ELECTROCARDIOLOGY	1,089					9,815	
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED				44,494		8,080	
055 30 IMPL. DEV. CHARGED TO PAT						7,222	
056 DRUGS CHARGED TO PATIENTS					41,163	19,916	
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
061 EMERGENCY	6,496		6,208			36,137	
062 OBSERVATION BEDS (NON-DIS							
062 OTHER REIMBURS COST CNTRS							
064 HOME PROGRAM DIALYSIS							
065 AMBULANCE SERVICES							
066 DURABLE MEDICAL EQUIP-REN							
067 DURABLE MEDICAL EQUIP-SOL							
069 CORF							
070 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
083 SPEC PURPOSE COST CENTERS							
083 KIDNEY ACQUISITION							
084 LIVER ACQUISITION							
085 HEART ACQUISITION							
086 OTHER ORGAN ACQUISITION							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	40,507		22,053	44,494	41,163	250,413	
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP							
097 RESEARCH							

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART III

COST CENTER DESCRIPTION	CAFETERIA	MAINTENANCE O F PERSONNEL	NURSING ADMIN ISTRATION	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E
NONREIMBURS COST CENTERS	12	13	14	15	16	17	18
098 PHYSICIANS' PRIVATE OFFIC							
098 01 PHYSICIANS' PRIVATE OFFIC							
098 02 CLAY COUNTY - CLINIC							
098 03 MISSION SERVICES							
098 04 PUBLIC RELATIONS	238						
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS							
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	40,745		22,053	44,494	41,163	250,413	

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	I&R SERVICES-SALARY & FRI	I&R SERVICES-OTHER PRGM C	PARAMED ED PR GM	SUBTOTAL	POST STEPDOWN ADJUSTMENT
	20	21	22	23	24	25	26
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
004 01 NEW CAP REL COSTS-MVBLE E							
005 NEW CAP REL COSTS-MOB BLD							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE							
011 HOUSEKEEPING							
012 DIETARY							
013 CAFETERIA							
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION							
016 CENTRAL SERVICES & SUPPLY							
017 PHARMACY							
018 MEDICAL RECORDS & LIBRARY							
019 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CNTRS						332,158	
026 ADULTS & PEDIATRICS							
027 INTENSIVE CARE UNIT							
028 CORONARY CARE UNIT							
029 BURN INTENSIVE CARE UNIT							
030 SURGICAL INTENSIVE CARE U							
031 SUBPROVIDER							
032 NURSERY							
033 SKILLED NURSING FACILITY							
034 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM						143,707	
039 RECOVERY ROOM							
040 DELIVERY ROOM & LABOR ROO							
041 ANESTHESIOLOGY							
042 RADIOLOGY-DIAGNOSTIC						165,337	
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
045 LABORATORY						159,867	
046 PBP CLINICAL LAB SERVICES							
047 WHOLE BLOOD & PACKED RED							
048 BLOOD STORING, PROCESSING							
049 INTRAVENOUS THERAPY							
050 RESPIRATORY THERAPY						55,603	
051 PHYSICAL THERAPY						146,348	
052 OCCUPATIONAL THERAPY							
053 SPEECH PATHOLOGY						90	
054 ELECTROCARDIOLOGY						18,258	
055 ELECTROENCEPHALOGRAPHY							
056 MEDICAL SUPPLIES CHARGED						75,325	
057 30 IMPL. DEV. CHARGED TO PAT						13,571	
058 DRUGS CHARGED TO PATIENTS						93,023	
059 RENAL DIALYSIS							
060 ASC (NON-DISTINCT PART)							
061 OUTPAT SERVICE COST CNTRS							
062 CLINIC							
063 EMERGENCY						259,382	
064 OBSERVATION BEDS (NON-DIS							
065 OTHER REIMBURS COST CNTRS							
066 HOME PROGRAM DIALYSIS							
067 AMBULANCE SERVICES							
068 DURABLE MEDICAL EQUIP-REN							
069 DURABLE MEDICAL EQUIP-SOL							
070 CORF							
071 I&R SERVICES-NOT APPRVD P							
072 HOME HEALTH AGENCY							
073 LUNG ACQUISITION							
074 SPEC PURPOSE COST CENTERS							
075 KIDNEY ACQUISITION							
076 LIVER ACQUISITION							
077 HEART ACQUISITION							
078 OTHER ORGAN ACQUISITION							
079 AMBULATORY SURGICAL CENTE							
080 HOSPICE							
081 SUBTOTALS						1,462,669	
082 NONREIMBURS COST CENTERS							
083 GIFT, FLOWER, COFFEE SHOP						5,708	
084 RESEARCH							

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART III

COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	I&R SERVICES- SALARY & FRI	I&R SERVICES- OTHER PRGM C	PARAMED ED PR GM	SUBTOTAL	POST STEPDOWN ADJUSTMENT
	20	21	22	23	24	25	26
098 NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC						289,694	
098 01 PHYSICIANS' PRIVATE OFFIC						36,829	
098 02 CLAY COUNTY - CLINIC						7	
098 03 MISSION SERVICES						13,041	
098 04 PUBLIC RELATIONS							
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS						50,029	
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL						1,857,977	

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART III

TOTAL

27

001	GENERAL SERVICE COST CNTR	
002	OLD CAP REL COSTS-BLDG &	
003	OLD CAP REL COSTS-MVBLE E	
004	NEW CAP REL COSTS-BLDG &	
004	NEW CAP REL COSTS-MVBLE E	
004	01 NEW CAP REL COSTS-MOB BLD	
005	EMPLOYEE BENEFITS	
006	ADMINISTRATIVE & GENERAL	
007	MAINTENANCE & REPAIRS	
008	OPERATION OF PLANT	
009	LAUNDRY & LINEN SERVICE	
010	HOUSEKEEPING	
011	DIETARY	
012	CAFETERIA	
013	MAINTENANCE OF PERSONNEL	
014	NURSING ADMINISTRATION	
015	CENTRAL SERVICES & SUPPLY	
016	PHARMACY	
017	MEDICAL RECORDS & LIBRARY	
018	SOCIAL SERVICE	
020	NONPHYSICIAN ANESTHETISTS	
021	NURSING SCHOOL	
022	I&R SERVICES-SALARY & FRI	
023	I&R SERVICES-OTHER PRGM C	
024	PARAMED ED PRGM	
025	INPAT ROUTINE SRVC CNTRS	332,158
026	ADULTS & PEDIATRICS	
027	INTENSIVE CARE UNIT	
028	CORONARY CARE UNIT	
029	BURN INTENSIVE CARE UNIT	
031	SURGICAL INTENSIVE CARE U	
033	SUBPROVIDER	
034	NURSERY	
035	SKILLED NURSING FACILITY	
035	01 NURSING FACILITY	
036	01 ICF/MR	
037	OTHER LONG TERM CARE	
038	ANCILLARY SRVC COST CNTRS	
039	OPERATING ROOM	143,707
040	RECOVERY ROOM	
041	DELIVERY ROOM & LABOR ROO	
042	ANESTHESIOLOGY	
043	RADIOLOGY-DIAGNOSTIC	165,337
044	RADIOLOGY-THERAPEUTIC	
045	RADIOISOTOPE	
046	LABORATORY	159,867
047	PBP CLINICAL LAB SERVICES	
048	WHOLE BLOOD & PACKED RED	
049	BLOOD STORING, PROCESSING	
050	INTRAVENOUS THERAPY	
051	RESPIRATORY THERAPY	55,603
052	PHYSICAL THERAPY	146,348
053	OCCUPATIONAL THERAPY	
054	SPEECH PATHOLOGY	90
055	ELECTROCARDIOLOGY	18,258
056	ELECTROENCEPHALOGRAPHY	
057	MEDICAL SUPPLIES CHARGED	75,325
058	30 IMPL. DEV. CHARGED TO PAT	13,571
060	DRUGS CHARGED TO PATIENTS	93,023
061	RENAL DIALYSIS	
062	ASC (NON-DISTINCT PART)	
063	OUTPAT SERVICE COST CNTRS	
064	CLINIC	
065	EMERGENCY	259,382
066	OBSERVATION BEDS (NON-DIS	
067	OTHER REIMBURS COST CNTRS	
068	HOME PROGRAM DIALYSIS	
069	AMBULANCE SERVICES	
070	DURABLE MEDICAL EQUIP-REN	
071	DURABLE MEDICAL EQUIP-SOL	
072	CORF	
073	I&R SERVICES-NOT APPRVD P	
074	HOME HEALTH AGENCY	
075	LUNG ACQUISITION	
076	SPEC PURPOSE COST CENTERS	
077	KIDNEY ACQUISITION	
078	LIVER ACQUISITION	
079	HEART ACQUISITION	
080	OTHER ORGAN ACQUISITION	
081	AMBULATORY SURGICAL CENTE	
082	HOSPICE	
083	SUBTOTALS	1,462,669
084	NONREIMBURS COST CENTERS	
085	GIFT, FLOWER, COFFEE SHOP	5,708
086	RESEARCH	

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART III

TOTAL

27

	NONREIMBURS COST CENTERS	
098	PHYSICIANS' PRIVATE OFFIC	
098 01	PHYSICIANS' PRIVATE OFFIC	289,694
098 02	CLAY COUNTY - CLINIC	36,829
098 03	MISSION SERVICES	7
098 04	PUBLIC RELATIONS	13,041
099	NONPAID WORKERS	
100	OTHER NONREIMBURSABLE COS	50,029
101	CROSS FOOT ADJUSTMENTS	
102	NEGATIVE COST CENTER	
103	TOTAL	1,857,977

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B-1
 I I TO 6/30/2010 I

COST CENTER DESCRIPTION	OLD CAP REL C	OLD CAP REL C	NEW CAP REL C	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE
	OSTS-BLDG &	OSTS-MVBLE E	OSTS-BLDG &	OSTS-MVBLE E	OSTS-MOB BLD	FITS
	(SQUARE FEET	(DOLLAR VALUE	(SQUARE FEET	(SQUARE FEET	(SQUARE FEET	(GROSS SALARIES
	1	2	3	4	4.01	5
001 GENERAL SERVICE COST						
002 OLD CAP REL COSTS-BLD						
003 OLD CAP REL COSTS-MVB						
004 NEW CAP REL COSTS-BLD			82,473			
004 NEW CAP REL COSTS-MVB				84,265		
004 01 NEW CAP REL COSTS-MOB					24,674	
005 EMPLOYEE BENEFITS						6,519,599
006 ADMINISTRATIVE & GENE			27,391	27,391	1,230	1,615,021
007 MAINTENANCE & REPAIRS						
008 OPERATION OF PLANT			16,925	16,925		300,792
009 LAUNDRY & LINEN SERVI			1,769	1,769		
010 HOUSEKEEPING			981	981		217,858
011 DIETARY			2,179	2,179		118,093
012 CAFETERIA			1,236	1,236		134,512
013 MAINTENANCE OF PERSON						
014 NURSING ADMINISTRATIO			270	270		201,887
015 CENTRAL SERVICES & SU			1,497	1,497		
016 PHARMACY			968	968		
017 MEDICAL RECORDS & LIB			8,582	8,582		299,205
018 SOCIAL SERVICE						
020 NONPHYSICIAN ANESTHET						
021 NURSING SCHOOL						
022 I&R SERVICES-SALARY &						
023 I&R SERVICES-OTHER PR						
024 PARAMED ED PRGM						
025 INPAT ROUTINE SRVC CN						
026 ADULTS & PEDIATRICS			5,571	5,571		1,002,546
027 INTENSIVE CARE UNIT						
028 CORONARY CARE UNIT						
028 BURN INTENSIVE CARE U						
029 SURGICAL INTENSIVE CA						
031 SUBPROVIDER						
033 NURSERY						
034 SKILLED NURSING FACIL						
035 NURSING FACILITY						
035 01 ICF/MR						
036 OTHER LONG TERM CARE						
037 ANCILLARY SRVC COST C						
038 OPERATING ROOM			2,287	2,287		499,613
038 RECOVERY ROOM						
039 DELIVERY ROOM & LABOR						
040 ANESTHESIOLOGY						
041 RADIOLOGY-DIAGNOSTIC			1,586	1,586		590,486
042 RADIOLOGY-THERAPEUTIC						
043 RADIOISOTOPE						
044 LABORATORY			1,297	1,297	983	376,091
045 PBP CLINICAL LAB SERV						
046 WHOLE BLOOD & PACKED						
047 BLOOD STORING, PROCES						
048 INTRAVENOUS THERAPY						
049 RESPIRATORY THERAPY			1,564	1,564		139,483
050 PHYSICAL THERAPY			1,661	1,661	2,902	
051 OCCUPATIONAL THERAPY						
052 SPEECH PATHOLOGY						
053 ELECTROCARDIOLOGY						115,293
054 ELECTROENCEPHALOGRAPH						
055 MEDICAL SUPPLIES CHAR						
055 30 IMPL. DEV. CHARGED TO						
056 DRUGS CHARGED TO PATI						
057 RENAL DIALYSIS						
058 ASC (NON-DISTINCT PAR						
060 OUTPAT SERVICE COST C						
061 CLINIC						
061 EMERGENCY			4,589	4,589		703,976
062 OBSERVATION BEDS (NON						
062 OTHER REIMBURS COST C						
064 HOME PROGRAM DIALYSIS						
065 AMBULANCE SERVICES						
066 DURABLE MEDICAL EQUIP						
067 DURABLE MEDICAL EQUIP						
069 CORF						
070 I&R SERVICES-NOT APPR						
071 HOME HEALTH AGENCY						
082 LUNG ACQUISITION						
082 SPEC PURPOSE COST CEN						
083 KIDNEY ACQUISITION						
084 LIVER ACQUISITION						
085 HEART ACQUISITION						
086 OTHER ORGAN ACQUISITI						
092 AMBULATORY SURGICAL C						
093 HOSPICE						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B-1
 I I TO 6/30/2010 I

COST CENTER DESCRIPTION	OLD CAP REL C	OLD CAP REL C	NEW CAP REL C	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE
	OSTS-BLDG &	OSTS-MVBLE E	OSTS-BLDG &	OSTS-MVBLE E	OSTS-MOB BLD	FITS
	(SQUARE FEET	(DOLLAR)VALUE	(SQUARE) FEET	(SQUARE) FEET	(SQUARE) FEET	(GROSS)ALARIES
	1	2	3	4	4.01	5
095 SPEC PURPOSE COST CEN						
095 SUBTOTALS			80,353	80,353	5,115	6,314,856
096 NONREIMBURS COST CENT						
096 GIFT, FLOWER, COFFEE			212	212		
097 RESEARCH						
098 PHYSICIANS' PRIVATE O						
098 01 PHYSICIANS' PRIVATE O					19,559	
098 02 CLAY COUNTY - CLINIC				1,792		183,535
098 03 MISSION SERVICES						
098 04 PUBLIC RELATIONS			50	50		21,208
099 NONPAID WORKERS						
100 OTHER NONREIMBURSABLE			1,858	1,858		
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED (WRKSHT B, PART I)			442,106	1,064,331	351,540	2,153,047
104 UNIT COST MULTIPLIER (WRKSHT B, PT I)			5.360615		14.247386	
105 COST TO BE ALLOCATED (WRKSHT B, PART II)				12.630760		.330242
106 UNIT COST MULTIPLIER (WRKSHT B, PT II)						
107 COST TO BE ALLOCATED (WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER (WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B-1
 I I TO 6/30/2010 I

COST CENTER DESCRIPTION	RECONCILIATION	ADMINISTRATIVE MAINTENANCE & OPERATION OF PLANT		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	S
		ACCUM. COST	(SQUARE) FEET	(SQUARE) FEET	(POUNDS OF) LAUNDRY	(HOURS OF) SERVICE	
	6a.00	6	7	8	9	10	11
001 GENERAL SERVICE COST							
002 OLD CAP REL COSTS-BLD							
003 OLD CAP REL COSTS-MVB							
004 NEW CAP REL COSTS-BLD							
004 01 NEW CAP REL COSTS-MVB							
005 NEW CAP REL COSTS-MOB							
006 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENE	-4,641,961	13,540,987					
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT		1,131,112		42,042			
009 LAUNDRY & LINEN SERVI		109,181		1,769	130,486		
010 HOUSEKEEPING		367,094		981	4,018	754	
011 DIETARY		242,663		2,179	1,872	24	100
012 CAFETERIA		213,049		1,236		5	
013 MAINTENANCE OF PERSON							
014 NURSING ADMINISTRATIO		291,261		270		35	
015 CENTRAL SERVICES & SU		138,004		1,497			
016 PHARMACY		418,018		968			
017 MEDICAL RECORDS & LIB		568,882		8,582		9	
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHET							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY &							
023 I&R SERVICES-OTHER PR							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CN							
025 ADULTS & PEDIATRICS		1,497,765		5,571	44,425	224	100
026 INTENSIVE CARE UNIT							
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE U							
029 SURGICAL INTENSIVE CA							
031 SUBPROVIDER							
033 NURSERY							
034 SKILLED NURSING FACIL							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST C							
037 OPERATING ROOM		835,301		2,287	20,760	69	
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC		1,132,666		1,586	16,051	40	
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY		1,272,505		2,280		55	
045 PBP CLINICAL LAB SERV							
046 WHOLE BLOOD & PACKED							
047 BLOOD STORING, PROCES							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY		228,765		1,564			
050 PHYSICAL THERAPY		628,822		4,563	2,954	60	
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY		1,744					
053 ELECTROCARDIOLOGY		166,193				20	
054 ELECTROENCEPHALOGRAPH							
055 MEDICAL SUPPLIES CHAR		603,672					
055 30 IMPL. DEV. CHARGED TO		168,476					
056 DRUGS CHARGED TO PATI		825,895				15	
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PAR							
060 OUTPAT SERVICE COST C							
060 CLINIC							
061 EMERGENCY		1,688,317		4,589	40,406	198	
062 OBSERVATION BEDS (NON							
062 OTHER REIMBURS COST C							
064 HOME PROGRAM DIALYSIS							
065 AMBULANCE SERVICES							
066 DURABLE MEDICAL EQUIP							
067 DURABLE MEDICAL EQUIP							
069 CORF							
070 I&R SERVICES-NOT APPR							
071 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
082 SPEC PURPOSE COST CEN							
083 KIDNEY ACQUISITION							
084 LIVER ACQUISITION							
085 HEART ACQUISITION							
086 OTHER ORGAN ACQUISITI							
092 AMBULATORY SURGICAL C							
093 HOSPICE							

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B-1
 I I TO 6/30/2010 I

COST CENTER DESCRIPTION	RECONCILIATION	ADMINISTRATIVE & GENERAL		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	S
		(ACCUM. COST	(SQUARE FEET	(SQUARE FEET	(POUNDS OF LAUNDRY	(HOURS OF SERVICE	(MEALS SERVED		
	6a.00	6	7	8	9	10	11		
095 SPEC PURPOSE COST CEN									
095 SUBTOTALS	-4,641,961	12,529,385		39,922	130,486	754	100		
096 NONREIMBURS COST CENT									
096 GIFT, FLOWER, COFFEE		3,814		212					
097 RESEARCH									
098 PHYSICIANS' PRIVATE O									
098 01 PHYSICIANS' PRIVATE O		292,649							
098 02 CLAY COUNTY - CLINIC		376,654							
098 03 MISSION SERVICES		185							
098 04 PUBLIC RELATIONS		304,872		50					
099 NONPAID WORKERS									
100 OTHER NONREIMBURSABLE		33,428		1,858					
101 CROSS FOOT ADJUSTMENT									
102 NEGATIVE COST CENTER									
103 COST TO BE ALLOCATED		4,641,961		1,518,866	210,518	534,860	424,616		
(WRKSHT B, PART I)									
104 UNIT COST MULTIPLIER		.342808		36.127349		709.363395	4,246.160000		
(WRKSHT B, PT I)					1.613338				
105 COST TO BE ALLOCATED									
(WRKSHT B, PART II)									
106 UNIT COST MULTIPLIER									
(WRKSHT B, PT II)									
107 COST TO BE ALLOCATED		510,323		347,132	50,548	41,142	68,375		
(WRKSHT B, PART III)									
108 UNIT COST MULTIPLIER		.037687		8.256791		54.564987	683.750000		
(WRKSHT B, PT III)					.387383				

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B-1
 I I TO 6/30/2010 I

COST CENTER DESCRIPTION	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT) (SING HRS)	CENTRAL SERVICES & SUPPLY (NR(COSTED) (EQUIS.	PHARMACY (R(COSTED) (EQUIS.	MEDICAL RECORDS & LIBRARY (R(TIME) (SPENT)	SOCIAL SERVICE (TIME) (SPENT)
	12	13	14	15	16	17	18
001 GENERAL SERVICE COST							
002 OLD CAP REL COSTS-BLD							
003 OLD CAP REL COSTS-MVB							
004 NEW CAP REL COSTS-BLD							
004 01 NEW CAP REL COSTS-MVB							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENE							
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVI							
010 HOUSEKEEPING							
011 DIETARY							
012 CAFETERIA	8,718						
013 MAINTENANCE OF PERSON							
014 NURSING ADMINISTRATION	445		4,938				
015 CENTRAL SERVICES & SU				100			
016 PHARMACY					100		
017 MEDICAL RECORDS & LIB	689					51,028,892	
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHET							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY &							
023 I&R SERVICES-OTHER PR							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CN							
025 ADULTS & PEDIATRICS	2,307		2,307			2,158,455	
026 INTENSIVE CARE UNIT							
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE U							
029 SURGICAL INTENSIVE CA							
031 SUBPROVIDER							
033 NURSERY							
034 SKILLED NURSING FACIL							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST C							
037 OPERATING ROOM	1,241		1,241			5,919,623	
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	1,147					13,704,286	
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY	892					9,899,126	
045 PBP CLINICAL LAB SERV							
046 WHOLE BLOOD & PACKED							
047 BLOOD STORING, PROCES							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	323					900,494	
050 PHYSICAL THERAPY						1,900,465	
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY						4,794	
053 ELECTROCARDIOLOGY	233					2,000,137	
054 ELECTROENCEPHALOGRAPH							
055 MEDICAL SUPPLIES CHAR				100		1,646,649	
055 30 IMPL. DEV. CHARGED TO						1,471,764	
056 DRUGS CHARGED TO PATI					100	4,058,690	
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PAR							
060 OUTPAT SERVICE COST C							
060 CLINIC							
061 EMERGENCY	1,390		1,390			7,364,409	
062 OBSERVATION BEDS (NON							
062 OTHER REIMBURS COST C							
064 HOME PROGRAM DIALYSIS							
065 AMBULANCE SERVICES							
066 DURABLE MEDICAL EQUIP							
067 DURABLE MEDICAL EQUIP							
069 CORF							
070 I&R SERVICES-NOT APPR							
071 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
082 SPEC PURPOSE COST CEN							
083 KIDNEY ACQUISITION							
084 LIVER ACQUISITION							
085 HEART ACQUISITION							
086 OTHER ORGAN ACQUISITI							
092 AMBULATORY SURGICAL C							
093 HOSPICE							

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET B-1
 I I TO 6/30/2010 I

	COST CENTER DESCRIPTION	CAFETERIA	MAINTENANCE O	NURSING ADMIN	CENTRAL SERVI	PHARMACY	MEDICAL RECOR	SOCIAL SERVIC
		(MEALS ERVED	F PERSONNEL	ISTRATION	ES & SUPPLY	R(COSTED)EQUIS.	S & LIBRARY	E
		12	13	14	15	16	17	18
095	SPEC PURPOSE COST CEN							
	SUBTOTALS	8,667		4,938	100	100	51,028,892	
096	NONREIMBURS COST CENT							
097	GIFT, FLOWER, COFFEE							
098	RESEARCH							
098	PHYSICIANS' PRIVATE O							
098	01 PHYSICIANS' PRIVATE O							
098	02 CLAY COUNTY - CLINIC							
098	03 MISSION SERVICES							
098	04 PUBLIC RELATIONS	51						
099	NONPAID WORKERS							
100	OTHER NONREIMBURSABLE							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED	334,284		442,753	239,396	596,289	1,106,750	
	(WRKSHT B, PART I)							
104	UNIT COST MULTIPLIER				2,393.960000		.021689	
	(WRKSHT B, PT I)	38.344116		89.662414		5,962.890000		
105	COST TO BE ALLOCATED							
	(WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER							
	(WRKSHT B, PT II)							
107	COST TO BE ALLOCATED	40,745		22,053	44,494	41,163	250,413	
	(WRKSHT B, PART III)							
108	UNIT COST MULTIPLIER				444.940000		.004907	
	(WRKSHT B, PT III)	4.673664		4.465978		411.630000		

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/1/2009 I WORKSHEET B-1
 I I TO 6/30/2010 I

COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	I&R SERVICES- SALARY & FRI	I&R SERVICES- OTHER PRGM C	PARAMED ED PR GM
	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(SQUARE FEET)
	20	21	22	23	24
001 GENERAL SERVICE COST					
002 OLD CAP REL COSTS-BLD					
003 OLD CAP REL COSTS-MVB					
004 NEW CAP REL COSTS-BLD					
004 01 NEW CAP REL COSTS-MVB					
005 NEW CAP REL COSTS-MOB					
006 EMPLOYEE BENEFITS					
007 ADMINISTRATIVE & GENE					
008 MAINTENANCE & REPAIRS					
009 OPERATION OF PLANT					
010 LAUNDRY & LINEN SERVI					
011 HOUSEKEEPING					
012 DIETARY					
013 CAFETERIA					
014 MAINTENANCE OF PERSON					
015 NURSING ADMINISTRATIO					
016 CENTRAL SERVICES & SU					
017 PHARMACY					
020 MEDICAL RECORDS & LIB					
021 SOCIAL SERVICE					
022 NONPHYSICIAN ANESTHET					
023 NURSING SCHOOL					
024 I&R SERVICES-SALARY &					
025 I&R SERVICES-OTHER PR					
026 PARAMED ED PRGM					23,444
027 INPAT ROUTINE SRVC CN					
028 ADULTS & PEDIATRICS					
029 INTENSIVE CARE UNIT					
031 CORONARY CARE UNIT					
033 BURN INTENSIVE CARE U					
034 SURGICAL INTENSIVE CA					
035 SUBPROVIDER					
036 NURSERY					
037 SKILLED NURSING FACIL					
038 NURSING FACILITY					
035 01 ICF/MR					
036 OTHER LONG TERM CARE					
037 ANCILLARY SRVC COST C					
038 OPERATING ROOM					
039 RECOVERY ROOM					
040 DELIVERY ROOM & LABOR					
041 ANESTHESIOLOGY					
042 RADIOLOGY-DIAGNOSTIC					
043 RADIOLOGY-THERAPEUTIC					
044 RADIOISOTOPE					
045 LABORATORY					983
046 PBP CLINICAL LAB SERV					
047 WHOLE BLOOD & PACKED					
048 BLOOD STORING, PROCES					
049 INTRAVENOUS THERAPY					
050 RESPIRATORY THERAPY					
051 PHYSICAL THERAPY					2,902
052 OCCUPATIONAL THERAPY					
053 SPEECH PATHOLOGY					
054 ELECTROCARDIOLOGY					
055 ELECTROENCEPHALOGRAPH					
055 30 MEDICAL SUPPLIES CHAR					
056 IMPL. DEV. CHARGED TO					
057 DRUGS CHARGED TO PATI					
058 RENAL DIALYSIS					
060 ASC (NON-DISTINCT PAR					
061 OUTPAT SERVICE COST C					
062 CLINIC					
064 EMERGENCY					
065 OBSERVATION BEDS (NON					
066 OTHER REIMBURS COST C					
067 HOME PROGRAM DIALYSIS					
068 AMBULANCE SERVICES					
069 DURABLE MEDICAL EQUIP					
070 DURABLE MEDICAL EQUIP					
071 CORF					
072 I&R SERVICES-NOT APPR					
073 HOME HEALTH AGENCY					
074 LUNG ACQUISITION					
075 SPEC PURPOSE COST CEN					
076 KIDNEY ACQUISITION					
077 LIVER ACQUISITION					
078 HEART ACQUISITION					
079 OTHER ORGAN ACQUISITI					
080 AMBULATORY SURGICAL C					
081 HOSPICE					

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO:	I PERIOD:	I PREPARED 11/30/2010
I 15-1309	I FROM 7/ 1/2009	I WORKSHEET B-1
I	I TO 6/30/2010	I

COST CENTER DESCRIPTION	NONPHYSICIAN	NURSING SCHOOL	I&R SERVICES-	I&R SERVICES-	PARAMED ED PR
	ANESTHETISTS	L	SALARY & FRI	OTHER PRGM C	GM
	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(SQUARE FEET)
	20	21	22	23	24
095 SPEC PURPOSE COST CEN					
095 SUBTOTALS					3,885
096 NONREIMBURS COST CEN					
096 GIFT, FLOWER, COFFEE					
097 RESEARCH					
098 PHYSICIANS' PRIVATE O					
098 01 PHYSICIANS' PRIVATE O					19,559
098 02 CLAY COUNTY - CLINIC					
098 03 MISSION SERVICES					
098 04 PUBLIC RELATIONS					
099 NONPAID WORKERS					
100 OTHER NONREIMBURSABLE					
101 CROSS FOOT ADJUSTMENT					
102 NEGATIVE COST CENTER					
103 COST TO BE ALLOCATED					
104 (PER WRKSHT B, PART					
104 UNIT COST MULTIPLIER					
105 (WRKSHT B, PT I)					
105 COST TO BE ALLOCATED					
106 (PER WRKSHT B, PART					
106 UNIT COST MULTIPLIER					
107 (WRKSHT B, PT II)					
107 COST TO BE ALLOCATED					
108 (PER WRKSHT B, PART					
108 UNIT COST MULTIPLIER					
108 (WRKSHT B, PT III)					

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET C
 I I TO 6/30/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	3,209,787		3,209,787		
26	INTENSIVE CARE UNIT					
27	CORONARY CARE UNIT					
28	BURN INTENSIVE CARE UNIT					
29	SURGICAL INTENSIVE CARE U					
31	SUBPROVIDER					
33	NURSERY					
34	SKILLED NURSING FACILITY					
35	NURSING FACILITY					
35	01 ICF/MR					
36	OTHER LONG TERM CARE ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,573,958		1,573,958		
38	RECOVERY ROOM					
39	DELIVERY ROOM & LABOR ROO					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	1,973,719		1,973,719		
42	RADIOLOGY-THERAPEUTIC					
43	RADIOISOTOPE					
44	LABORATORY	2,079,020		2,079,020		
45	PBP CLINICAL LAB SERVICES					
46	WHOLE BLOOD & PACKED RED					
47	BLOOD STORING, PROCESSING					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	395,606		395,606		
50	PHYSICAL THERAPY	1,097,783		1,097,783		
51	OCCUPATIONAL THERAPY					
52	SPEECH PATHOLOGY	2,446		2,446		
53	ELECTROCARDIOLOGY	289,667		289,667		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	1,085,726		1,085,726		
55	30 IMPL. DEV. CHARGED TO PAT	258,152		258,152		
56	DRUGS CHARGED TO PATIENTS	1,803,976		1,803,976		
57	RENAL DIALYSIS					
58	ASC (NON-DISTINCT PART) OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	2,976,176		2,976,176		
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	442,892		442,892		
64	HOME PROGRAM DIALYSIS					
65	AMBULANCE SERVICES					
66	DURABLE MEDICAL EQUIP-REN					
67	DURABLE MEDICAL EQUIP-SOL					
101	SUBTOTAL	17,188,908		17,188,908		
102	LESS OBSERVATION BEDS	442,892		442,892		
103	TOTAL	16,746,016		16,746,016		

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,158,455		2,158,455			
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
31	SUBPROVIDER						
33	NURSERY						
34	SKILLED NURSING FACILITY						
35	NURSING FACILITY						
35	01 ICF/MR						
36	OTHER LONG TERM CARE ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,077,507	4,842,116	5,919,623	.265888	.265888	
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	2,765,844	10,938,442	13,704,286	.144022	.144022	
42	RADIOLOGY-THERAPEUTIC						
43	RADIOISOTOPE						
44	LABORATORY	2,027,733	7,871,393	9,899,126	.210021	.210021	
45	PBP CLINICAL LAB SERVICES						
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	592,357	308,138	900,495	.439321	.439321	
50	PHYSICAL THERAPY	637,171	1,263,294	1,900,465	.577639	.577639	
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY	4,106	689	4,795	.510115	.510115	
53	ELECTROCARDIOLOGY	450,625	1,549,512	2,000,137	.144824	.144824	
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	880,417	766,232	1,646,649	.659355	.659355	
55	30 IMPL. DEV. CHARGED TO PAT	320,370	1,151,394	1,471,764	.175403	.175403	
56	DRUGS CHARGED TO PATIENTS	1,266,034	2,792,656	4,058,690	.444472	.444472	
57	RENAL DIALYSIS						
58	ASC (NON-DISTINCT PART)						
60	OUTPAT SERVICE COST CNTRS CLINIC						
61	EMERGENCY	1,702,851	5,661,558	7,364,409	.404130	.404130	
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS		435,818	435,818	1.016232	1.016232	
64	HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	13,883,470	37,581,242	51,464,712			
102	LESS OBSERVATION BEDS						
103	TOTAL	13,883,470	37,581,242	51,464,712			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
I 15-1309 I FROM 7/ 1/2009 I WORKSHEET C
I I TO 6/30/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	3,209,787		3,209,787		
26	INTENSIVE CARE UNIT					
27	CORONARY CARE UNIT					
28	BURN INTENSIVE CARE UNIT					
29	SURGICAL INTENSIVE CARE U					
31	SUBPROVIDER					
33	NURSERY					
34	SKILLED NURSING FACILITY					
35	NURSING FACILITY					
35	01 ICF/MR					
36	OTHER LONG TERM CARE ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,573,958		1,573,958		
38	RECOVERY ROOM					
39	DELIVERY ROOM & LABOR ROO					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	1,973,719		1,973,719		
42	RADIOLOGY-THERAPEUTIC					
43	RADIOISOTOPE					
44	LABORATORY	2,079,020		2,079,020		
45	PBP CLINICAL LAB SERVICES					
46	WHOLE BLOOD & PACKED RED					
47	BLOOD STORING, PROCESSING					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	395,606		395,606		
50	PHYSICAL THERAPY	1,097,783		1,097,783		
51	OCCUPATIONAL THERAPY					
52	SPEECH PATHOLOGY	2,446		2,446		
53	ELECTROCARDIOLOGY	289,667		289,667		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	1,085,726		1,085,726		
55	30 IMPL. DEV. CHARGED TO PAT	258,152		258,152		
56	DRUGS CHARGED TO PATIENTS	1,803,976		1,803,976		
57	RENAL DIALYSIS					
58	ASC (NON-DISTINCT PART) OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	2,976,176		2,976,176		
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	442,892		442,892		
64	HOME PROGRAM DIALYSIS					
65	AMBULANCE SERVICES					
66	DURABLE MEDICAL EQUIP-REN					
67	DURABLE MEDICAL EQUIP-SOL					
101	SUBTOTAL	17,188,908		17,188,908		
102	LESS OBSERVATION BEDS	442,892		442,892		
103	TOTAL	16,746,016		16,746,016		

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,158,455		2,158,455			
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
31	SUBPROVIDER						
33	NURSERY						
34	SKILLED NURSING FACILITY						
35	NURSING FACILITY						
35	01 ICF/MR						
36	OTHER LONG TERM CARE ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,077,507	4,842,116	5,919,623	.265888	.265888	
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	2,765,844	10,938,442	13,704,286	.144022	.144022	
42	RADIOLOGY-THERAPEUTIC						
43	RADIOISOTOPE						
44	LABORATORY	2,027,733	7,871,393	9,899,126	.210021	.210021	
45	PBP CLINICAL LAB SERVICES						
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	592,357	308,138	900,495	.439321	.439321	
50	PHYSICAL THERAPY	637,171	1,263,294	1,900,465	.577639	.577639	
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY	4,106	689	4,795	.510115	.510115	
53	ELECTROCARDIOLOGY	450,625	1,549,512	2,000,137	.144824	.144824	
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	880,417	766,232	1,646,649	.659355	.659355	
55	30 IMPL. DEV. CHARGED TO PAT	320,370	1,151,394	1,471,764	.175403	.175403	
56	DRUGS CHARGED TO PATIENTS	1,266,034	2,792,656	4,058,690	.444472	.444472	
57	RENAL DIALYSIS						
58	ASC (NON-DISTINCT PART) OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	1,702,851	5,661,558	7,364,409	.404130	.404130	
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS		435,818	435,818	1.016232	1.016232	
64	HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	13,883,470	37,581,242	51,464,712			
102	LESS OBSERVATION BEDS						
103	TOTAL	13,883,470	37,581,242	51,464,712			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	1,573,958	143,707	1,430,251			1,573,958
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	1,973,719	165,337	1,808,382			1,973,719
42	RADIOLOGY-THERAPEUTIC						
43	RADIOISOTOPE						
44	LABORATORY	2,079,020	159,867	1,919,153			2,079,020
45	PBP CLINICAL LAB SERVICES						
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	395,606	55,603	340,003			395,606
50	PHYSICAL THERAPY	1,097,783	146,348	951,435			1,097,783
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY	2,446	90	2,356			2,446
53	ELECTROCARDIOLOGY	289,667	18,258	271,409			289,667
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	1,085,726	75,325	1,010,401			1,085,726
55	30 IMPL. DEV. CHARGED TO PAT	258,152	13,571	244,581			258,152
56	DRUGS CHARGED TO PATIENTS	1,803,976	93,023	1,710,953			1,803,976
57	RENAL DIALYSIS						
58	ASC (NON-DISTINCT PART)						
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
61	EMERGENCY	2,976,176	259,382	2,716,794			2,976,176
62	OBSERVATION BEDS (NON-DIS	442,892		442,892			442,892
	OTHER REIMBURS COST CNTRS						
64	HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	13,979,121	1,130,511	12,848,610			13,979,121
102	LESS OBSERVATION BEDS	442,892		442,892			442,892
103	TOTAL	13,536,229	1,130,511	12,405,718			13,536,229

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
38	OPERATING ROOM	5,919,623	.265888	.265888
39	RECOVERY ROOM			
40	DELIVERY ROOM & LABOR ROO			
41	ANESTHESIOLOGY			
42	RADIOLOGY-DIAGNOSTIC	13,704,286	.144022	.144022
43	RADIOLOGY-THERAPEUTIC			
44	RADIOISOTOPE			
45	LABORATORY	9,899,126	.210021	.210021
46	PBP CLINICAL LAB SERVICES			
47	WHOLE BLOOD & PACKED RED			
48	BLOOD STORING, PROCESSING			
49	INTRAVENOUS THERAPY			
50	RESPIRATORY THERAPY	900,495	.439321	.439321
51	PHYSICAL THERAPY	1,900,465	.577639	.577639
52	OCCUPATIONAL THERAPY			
53	SPEECH PATHOLOGY	4,795	.510115	.510115
54	ELECTROCARDIOLOGY	2,000,137	.144824	.144824
55	ELECTROENCEPHALOGRAPHY			
56	MEDICAL SUPPLIES CHARGED	1,646,649	.659355	.659355
57	30 IMPL. DEV. CHARGED TO PAT	1,471,764	.175403	.175403
58	DRUGS CHARGED TO PATIENTS	4,058,690	.444472	.444472
59	RENAL DIALYSIS			
60	ASC (NON-DISTINCT PART)			
61	OUTPAT SERVICE COST CNTRS			
62	CLINIC			
63	EMERGENCY	7,364,409	.404130	.404130
64	OBSERVATION BEDS (NON-DIS	435,818	1.016232	1.016232
65	OTHER REIMBURS COST CNTRS			
66	HOME PROGRAM DIALYSIS			
67	AMBULANCE SERVICES			
101	DURABLE MEDICAL EQUIP-REN			
102	DURABLE MEDICAL EQUIP-SOL			
103	SUBTOTAL	49,306,257		
	LESS OBSERVATION BEDS	435,818		
	TOTAL	48,870,439		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	1,573,958	143,707	1,430,251			1,573,958
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	1,973,719	165,337	1,808,382			1,973,719
42	RADIOLOGY-THERAPEUTIC						
43	RADIOISOTOPE						
44	LABORATORY	2,079,020	159,867	1,919,153			2,079,020
45	PBP CLINICAL LAB SERVICES						
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	395,606	55,603	340,003			395,606
50	PHYSICAL THERAPY	1,097,783	146,348	951,435			1,097,783
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY	2,446	90	2,356			2,446
53	ELECTROCARDIOLOGY	289,667	18,258	271,409			289,667
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	1,085,726	75,325	1,010,401			1,085,726
55	30 IMPL. DEV. CHARGED TO PAT	258,152	13,571	244,581			258,152
56	DRUGS CHARGED TO PATIENTS	1,803,976	93,023	1,710,953			1,803,976
57	RENAL DIALYSIS						
58	ASC (NON-DISTINCT PART)						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	2,976,176	259,382	2,716,794			2,976,176
62	OBSERVATION BEDS (NON-DIS	442,892		442,892			442,892
	OTHER REIMBURS COST CNTRS						
64	HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	13,979,121	1,130,511	12,848,610			13,979,121
102	LESS OBSERVATION BEDS	442,892		442,892			442,892
103	TOTAL	13,536,229	1,130,511	12,405,718			13,536,229

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	5,919,623	.265888	.265888
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROO			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	13,704,286	.144022	.144022
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	9,899,126	.210021	.210021
45	PBP CLINICAL LAB SERVICES			
46	WHOLE BLOOD & PACKED RED			
47	BLOOD STORING, PROCESSING			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	900,495	.439321	.439321
50	PHYSICAL THERAPY	1,900,465	.577639	.577639
51	OCCUPATIONAL THERAPY			
52	SPEECH PATHOLOGY	4,795	.510115	.510115
53	ELECTROCARDIOLOGY	2,000,137	.144824	.144824
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	1,646,649	.659355	.659355
55	30 IMPL. DEV. CHARGED TO PAT	1,471,764	.175403	.175403
56	DRUGS CHARGED TO PATIENTS	4,058,690	.444472	.444472
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART)			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	7,364,409	.404130	.404130
62	OBSERVATION BEDS (NON-DIS	435,818	1.016232	1.016232
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-REN			
67	DURABLE MEDICAL EQUIP-SOL			
101	SUBTOTAL	49,306,257		
102	LESS OBSERVATION BEDS	435,818		
103	TOTAL	48,870,439		

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	.265888		.265888		
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC	.144022		.144022		
42 RADIOLOGY-THERAPEUTIC					
43 RADIOISOTOPE					
44 LABORATORY	.210021		.210021		
45 PBP CLINICAL LAB SERVICES-PRGM ONLY					
46 WHOLE BLOOD & PACKED RED BLOOD CELLS					
47 BLOOD STORING, PROCESSING & TRANS.					
48 INTRAVENOUS THERAPY					
49 RESPIRATORY THERAPY	.439321		.439321		
50 PHYSICAL THERAPY	.577639		.577639		
51 OCCUPATIONAL THERAPY					
52 SPEECH PATHOLOGY	.510115		.510115		
53 ELECTROCARDIOLOGY	.144824		.144824		
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.659355		.659355		
55 30 IMPL. DEV. CHARGED TO PATIENT	.175403		.175403		
56 DRUGS CHARGED TO PATIENTS	.444472		.444472		
57 RENAL DIALYSIS					
58 ASC (NON-DISTINCT PART)					
OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY	.404130		.404130		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.016232		1.016232		
OTHER REIMBURS COST CNTRS					
64 HOME PROGRAM DIALYSIS					
65 AMBULANCE SERVICES					
66 DURABLE MEDICAL EQUIP-RENTED					
67 DURABLE MEDICAL EQUIP-SOLD					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES					

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

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	4	5	6	7	8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		1,893,152			
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC		3,853,841			
42 RADIOLOGY-THERAPEUTIC					
43 RADIOISOTOPE					
44 LABORATORY		2,912,298			
45 PBP CLINICAL LAB SERVICES-PRGM ONLY					
46 WHOLE BLOOD & PACKED RED BLOOD CELLS					
47 BLOOD STORING, PROCESSING & TRANS.					
48 INTRAVENOUS THERAPY					
49 RESPIRATORY THERAPY		308,138			
50 PHYSICAL THERAPY		560,428			
51 OCCUPATIONAL THERAPY					
52 SPEECH PATHOLOGY		460			
53 ELECTROCARDIOLOGY		194,428			
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		766,232			
55 30 IMPL. DEV. CHARGED TO PATIENT		150,505			
56 DRUGS CHARGED TO PATIENTS		2,066,088			
57 RENAL DIALYSIS					
58 ASC (NON-DISTINCT PART)					
OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY		1,744,530			
62 OBSERVATION BEDS (NON-DISTINCT PART)		278,866			
OTHER REIMBURS COST CNTRS					
64 HOME PROGRAM DIALYSIS					
65 AMBULANCE SERVICES					
66 DURABLE MEDICAL EQUIP-RENTED					
67 DURABLE MEDICAL EQUIP-SOLD					
101 SUBTOTAL		14,728,966			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		14,728,966			

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII, PART B

HOSPITAL

	All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
Cost Center Description	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM	503,366		
38 RECOVERY ROOM			
39 DELIVERY ROOM & LABOR ROOM			
40 ANESTHESIOLOGY			
41 RADIOLOGY-DIAGNOSTIC	555,038		
42 RADIOLOGY-THERAPEUTIC			
43 RADIOISOTOPE			
44 LABORATORY	611,644		
45 PBP CLINICAL LAB SERVICES-PRGM ONLY			
46 WHOLE BLOOD & PACKED RED BLOOD CELLS			
47 BLOOD STORING, PROCESSING & TRANS.			
48 INTRAVENOUS THERAPY			
49 RESPIRATORY THERAPY	135,371		
50 PHYSICAL THERAPY	323,725		
51 OCCUPATIONAL THERAPY			
52 SPEECH PATHOLOGY	235		
53 ELECTROCARDIOLOGY	28,158		
54 ELECTROENCEPHALOGRAPHY			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	505,219		
55 30 IMPL. DEV. CHARGED TO PATIENT	26,399		
56 DRUGS CHARGED TO PATIENTS	918,318		
57 RENAL DIALYSIS			
58 ASC (NON-DISTINCT PART)			
OUTPAT SERVICE COST CNTRS			
60 CLINIC			
61 EMERGENCY	705,017		
62 OBSERVATION BEDS (NON-DISTINCT PART)	283,393		
OTHER REIMBURS COST CNTRS			
64 HOME PROGRAM DIALYSIS			
65 AMBULANCE SERVICES			
66 DURABLE MEDICAL EQUIP-RENTED			
67 DURABLE MEDICAL EQUIP-SOLD			
101 SUBTOTAL	4,595,883		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS-			
PROGRAM ONLY CHARGES			
104 NET CHARGES	4,595,883		

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

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1	.444472
2	PROGRAM VACCINE CHARGES		4,579
3	PROGRAM COSTS		2,035

COMPUTATION OF INPATIENT OPERATING COST

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,792
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,432
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,432
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	490
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)	720
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	150
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,403
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	490
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)	720
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	146.75
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	146.75
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,209,787
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	22,013
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,081,102
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,128,685

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,183,115
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,183,115
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.975068
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	897.66
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	2,128,685

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 875.28
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,228,018
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,228,018

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					1
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1,052,216
49 TOTAL PROGRAM INPATIENT COSTS					2,280,234

PASS THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST
 REPORTING PERIOD (SEE INSTRUCTIONS) 428,887
 61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST
 REPORTING PERIOD (SEE INSTRUCTIONS) 630,202
 62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS 1,059,089
 63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE
 COST REPORTING PERIOD
 64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE
 COST REPORTING PERIOD
 65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

TITLE XVIII PART A HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	506
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	875.28
85	OBSERVATION BED COST	442,892

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,792
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,432
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,432
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	1,210
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	150
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	148
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

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

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,183,115
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,183,115
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	897.66
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	

TITLE XIX - I/P HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM					
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					
		TOTAL	TOTAL	AVERAGE	PROGRAM	PROGRAM
		I/P COST	I/P DAYS	PER DIEM	DAYS	COST
		1	2	3	4	5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT					
	HOSPITAL UNITS					
43	INTENSIVE CARE UNIT					
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					
						1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST					2,034,446
49	TOTAL PROGRAM INPATIENT COSTS					2,034,446

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					2,034,446

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES					46
55	TARGET AMOUNT PER DISCHARGE					
56	TARGET AMOUNT					
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT					
58	BONUS PAYMENT					
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET					
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET					
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.					
58.04	RELIEF PAYMENT					
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT					
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)					
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1					
59.03	PROGRAM DISCHARGES AFTER JULY 1					
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)					
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)					
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)					
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)					
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)					

PROGRAM INPATIENT ROUTINE SWING BED COST

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

TITLE XIX - I/P HOSPITAL OTHER

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

506

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

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

WKST A LINE NO.	TITLE XVIII, PART A COST CENTER DESCRIPTION	HOSPITAL	OTHER		
			RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			1,204,804	
26	INTENSIVE CARE UNIT				
27	CORONARY CARE UNIT				
28	BURN INTENSIVE CARE UNIT				
29	SURGICAL INTENSIVE CARE UNIT				
31	SUBPROVIDER				
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM		.265888	293,418	78,016
38	RECOVERY ROOM				
39	DELIVERY ROOM & LABOR ROOM				
40	ANESTHESIOLOGY				
41	RADIOLOGY-DIAGNOSTIC		.144022	569,116	81,965
42	RADIOLOGY-THERAPEUTIC				
43	RADIOISOTOPE				
44	LABORATORY		.210021	557,152	117,014
45	PBP CLINICAL LAB SERVICES-PRGM ONLY				
46	WHOLE BLOOD & PACKED RED BLOOD CELLS				
47	BLOOD STORING, PROCESSING & TRANS.				
48	INTRAVENOUS THERAPY				
49	RESPIRATORY THERAPY		.439321	322,456	141,662
50	PHYSICAL THERAPY		.577639	101,629	58,705
51	OCCUPATIONAL THERAPY				
52	SPEECH PATHOLOGY		.510115	3,865	1,972
53	ELECTROCARDIOLOGY		.144824	47,625	6,897
54	ELECTROENCEPHALOGRAPHY				
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		.659355	462,724	305,099
55	30 IMPL. DEV. CHARGED TO PATIENT		.175403	78,201	13,717
56	DRUGS CHARGED TO PATIENTS		.444472	553,887	246,187
57	RENAL DIALYSIS				
58	ASC (NON-DISTINCT PART)				
60	OUTPAT SERVICE COST CNTRS CLINIC				
61	EMERGENCY		.404130	2,431	982
62	OBSERVATION BEDS (NON-DISTINCT PART)		1.016232		
64	OTHER REIMBURS COST CNTRS HOME PROGRAM DIALYSIS				
65	AMBULANCE SERVICES				
66	DURABLE MEDICAL EQUIP-RENTED				
67	DURABLE MEDICAL EQUIP-SOLD				
101	TOTAL			2,992,504	1,052,216
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES				
103	NET CHARGES			2,992,504	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

TITLE XVIII, PART A SWING BED SNF OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
27	CORONARY CARE UNIT			
28	BURN INTENSIVE CARE UNIT			
29	SURGICAL INTENSIVE CARE UNIT			
31	SUBPROVIDER ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.265888	6,633	1,764
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.144022	66,887	9,633
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	.210021	112,082	23,540
45	PBP CLINICAL LAB SERVICES-PRGM ONLY			
46	WHOLE BLOOD & PACKED RED BLOOD CELLS			
47	BLOOD STORING, PROCESSING & TRANS.			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	.439321	120,749	53,048
50	PHYSICAL THERAPY	.577639	355,760	205,501
51	OCCUPATIONAL THERAPY			
52	SPEECH PATHOLOGY	.510115	230	117
53	ELECTROCARDIOLOGY	.144824	2,443	354
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.659355	141,274	93,150
55	30 IMPL. DEV. CHARGED TO PATIENT	.175403		
56	DRUGS CHARGED TO PATIENTS	.444472	289,484	128,668
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART) OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.404130		
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS	1.016232		
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD			
101	TOTAL		1,095,542	515,775
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,095,542	

WKST A LINE NO.	TITLE XIX COST CENTER DESCRIPTION	HOSPITAL	OTHER		
			RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			190,523	
26	INTENSIVE CARE UNIT				
27	CORONARY CARE UNIT				
28	BURN INTENSIVE CARE UNIT				
29	SURGICAL INTENSIVE CARE UNIT				
31	SUBPROVIDER				
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM		.265888	777,456	206,716
38	RECOVERY ROOM				
39	DELIVERY ROOM & LABOR ROOM				
40	ANESTHESIOLOGY				
41	RADIOLOGY-DIAGNOSTIC		.144022	2,129,841	306,744
42	RADIOLOGY-THERAPEUTIC				
43	RADIOISOTOPE				
44	LABORATORY		.210021	1,358,499	285,313
45	PBP CLINICAL LAB SERVICES-PRGM ONLY				
46	WHOLE BLOOD & PACKED RED BLOOD CELLS				
47	BLOOD STORING, PROCESSING & TRANS.				
48	INTRAVENOUS THERAPY				
49	RESPIRATORY THERAPY		.439321	149,152	65,526
50	PHYSICAL THERAPY		.577639	179,782	103,849
51	OCCUPATIONAL THERAPY				
52	SPEECH PATHOLOGY		.510115		
53	ELECTROCARDIOLOGY		.144824	62,052	8,987
54	ELECTROENCEPHALOGRAPHY				
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		.659355	276,419	182,258
55	30 IMPL. DEV. CHARGED TO PATIENT		.175403		
56	DRUGS CHARGED TO PATIENTS		.444472	422,663	187,862
57	RENAL DIALYSIS				
58	ASC (NON-DISTINCT PART)				
60	OUTPAT SERVICE COST CNTRS CLINIC				
61	EMERGENCY		.404130	1,700,420	687,191
62	OBSERVATION BEDS (NON-DISTINCT PART)		1.016232		
64	OTHER REIMBURS COST CNTRS HOME PROGRAM DIALYSIS				
65	AMBULANCE SERVICES				
66	DURABLE MEDICAL EQUIP-RENTED				
67	DURABLE MEDICAL EQUIP-SOLD				
101	TOTAL			7,056,284	2,034,446
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES				
103	NET CHARGES			7,056,284	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/30/2010
I	15-1309	I	FROM 7/ 1/2009	I	WORKSHEET E
I	COMPONENT NO:	I	TO 6/30/2010	I	PART B
I	15-1309	I		I	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	4,597,918
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	ENTER THE AMOUNT FROM WORKSHEET D, PART 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)	4,597,918
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)	4,643,897
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	CAH DEDUCTIBLES	44,991
18.01	CAH ACTUAL BILLED COINSURANCE	2,372,360
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	2,226,546
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	2,226,546
24	PRIMARY PAYER PAYMENTS	3,284
25	SUBTOTAL	2,223,262
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	486,370
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	486,370
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	421,525
28	SUBTOTAL	2,709,632
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	2,709,632
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	2,666,656
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	42,976
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 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

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		2,017,594		2,675,566
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	5/20/2010	51,189	5/20/2010	295,458
ADJUSTMENTS TO PROVIDER .02	5/20/2010	30,596		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50	1/28/2010	134,931	1/28/2010	64,979
ADJUSTMENTS TO PROGRAM .51			5/20/2010	239,389
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		-53,146		-8,910
4 TOTAL INTERIM PAYMENTS		1,964,448		2,666,656
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)		26,710		42,976
7 TOTAL MEDICARE PROGRAM LIABILITY		1,991,158		2,709,632

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

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		1,459,483		
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	1/28/2010	15,232		
ADJUSTMENTS TO PROVIDER .02	5/20/2010	60,156		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
ADJUSTMENTS TO PROGRAM .99				
SUBTOTAL		75,388		NONE
4 TOTAL INTERIM PAYMENTS		1,534,871		
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
TENTATIVE TO PROGRAM .99				
SUBTOTAL		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01	40,067		
	SETTLEMENT TO PROGRAM .02			
7 TOTAL MEDICARE PROGRAM LIABILITY		1,574,938		

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 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I
 I COMPONENT NO: I TO 6/30/2010 I WORKSHEET E-2
 I 15-2309 I I

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	1,069,680	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	520,933	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	1,210	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	1,590,613	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	1,590,613	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	1,590,613	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS) (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	15,675	
14	80% OF PART B COSTS		
15	SUBTOTAL	1,574,938	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	1,574,938	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	1,534,871	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	40,067	
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 11/30/2010
I	15-1309	I	FROM 7/ 1/2009	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 6/30/2010	I	PART II
I	15-1309	I		I	

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	2,280,234
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	2,280,234
5	PRIMARY PAYER PAYMENTS	2,090
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	2,300,925

COMPUTATION OF LESSER OF COST OR CHARGES

7	REASONABLE CHARGES	
8	ROUTINE SERVICE CHARGES	
9	ANCILLARY SERVICE CHARGES	
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
11	TEACHING PHYSICIANS	
12	TOTAL REASONABLE CHARGES	
13	CUSTOMARY CHARGES	
14	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
15	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)	
16	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
17	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
18	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
19	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

20	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	2,300,925
21	COST OF COVERED SERVICES	345,640
22	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	
23	EXCESS REASONABLE COST	
24	SUBTOTAL	1,955,285
25	COINSURANCE	
26	SUBTOTAL	1,955,285
27	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	35,873
28.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	35,873
29.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	35,873
30	SUBTOTAL	1,991,158
31	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
32	OTHER ADJUSTMENTS (SPECIFY)	
33	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
34	SUBTOTAL	1,991,158
35	SEQUESTRATION ADJUSTMENT	
36	INTERIM PAYMENTS	1,964,448
37.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
38	BALANCE DUE PROVIDER/PROGRAM	26,710
39	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 11/30/2010
I	15-1309	I	FROM 7/ 1/2009	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 6/30/2010	I	PART III
I	-	I		I	

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

TITLE XIX	HOSPITAL	TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
COMPUTATION OF NET COST OF COVERED SERVICE			
1	INPATIENT HOSPITAL/SNF/NF SERVICES	2,034,446	
2	MEDICAL AND OTHER SERVICES		
3	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		
4	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)		
5	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		
6	SUBTOTAL	2,034,446	
7	INPATIENT PRIMARY PAYER PAYMENTS		
8	OUTPATIENT PRIMARY PAYER PAYMENTS		
9	SUBTOTAL	2,034,446	
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
10	ROUTINE SERVICE CHARGES	2,183,115	
11	ANCILLARY SERVICE CHARGES	7,056,284	
12	INTERNS AND RESIDENTS SERVICE CHARGES		
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE		
14	TEACHING PHYSICIANS		
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION		
16	TOTAL REASONABLE CHARGES	9,239,399	
CUSTOMARY CHARGES			
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
18	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)		
19	RATIO OF LINE 17 TO LINE 18		
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	9,239,399	
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	7,204,953	
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
23	COST OF COVERED SERVICES	2,034,446	
PROSPECTIVE PAYMENT AMOUNT			
24	OTHER THAN OUTLIER PAYMENTS		
25	OUTLIER PAYMENTS		
26	PROGRAM CAPITAL PAYMENTS		
27	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS		
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		
30	SUBTOTAL	2,034,446	
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)		
32	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE XVIII ENTER AMOUNT FROM LINE 30	2,034,446	
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)		
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34	EXCESS OF REASONABLE COST		
35	SUBTOTAL	2,034,446	
36	COINSURANCE		
37	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19		
38	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
38.01	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING BEFORE 10/01/05 (SEE INSTRUCTIONS)		
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)		
39	UTILIZATION REVIEW		
40	SUBTOTAL (SEE INSTRUCTIONS)	2,034,446	
41	INPATIENT ROUTINE SERVICE COST		
42	MEDICARE INPATIENT ROUTINE CHARGES		
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT OF PART A SERVICES		
45	RATIO OF LINE 43 TO 44		
46	TOTAL CUSTOMARY CHARGES		
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION		
50	OTHER ADJUSTMENTS (SPECIFY)		
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
52	SUBTOTAL	2,034,446	
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)		
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS		
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	2,034,446	
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
57	INTERIM PAYMENTS	2,034,311	
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
58	BALANCE DUE PROVIDER/PROGRAM	135	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO:	I PERIOD:	I PREPARED 11/30/2010
I 15-1309	I FROM 7/ 1/2009	I WORKSHEET E-3
I COMPONENT NO:	I TO 6/30/2010	I PART III
I -	I	I

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

TITLE XIX

HOSPITAL

TITLE V OR
TITLE XIX
1

TITLE XVIII
SNF PPS
2

59 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	4,361,450			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	5,082,215			
5	OTHER RECEIVABLES				
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-2,126,243			
7	INVENTORY	423,805			
8	PREPAID EXPENSES				
9	OTHER CURRENT ASSETS	349,124			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	8,090,351			
FIXED ASSETS					
12	LAND				
12.01					
13	LAND IMPROVEMENTS	320,447			
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	8,844,102			
14.01	LESS ACCUMULATED DEPRECIATION				
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT	8,813,402			
16.01	LESS ACCUMULATED DEPRECIATION	-11,391,165			
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	6,586,786			
OTHER ASSETS					
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	18,368,593	1,197,114		
26	TOTAL OTHER ASSETS	18,368,593	1,197,114		
27	TOTAL ASSETS	33,045,730	1,197,114		

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	1,008,812			
29 SALARIES, WAGES & FEES PAYABLE	1,277,391			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)				
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	1,743,800			
36 TOTAL CURRENT LIABILITIES	4,030,003			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	8,119,347			
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES	542,296			
42 TOTAL LONG-TERM LIABILITIES	8,661,643			
43 TOTAL LIABILITIES	12,691,646			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	20,354,084			
45 SPECIFIC PURPOSE FUND		1,197,114		
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	20,354,084	1,197,114		
52 TOTAL LIABILITIES AND FUND BALANCES	33,045,730	1,197,114		

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		15,332,434		1,060,199
2 NET INCOME (LOSS)		5,016,319		
3 TOTAL		20,348,753		1,060,199
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 CONTRIBUTIONS			58,975	
6 OTHER RESTRICTED ACTIVITY			121,970	
7 GRANT REVENUE			43,647	
8 RESTRICTED CONTRIBUTIONS	66,697			
9				
10 TOTAL ADDITIONS		66,697		224,592
11 SUBTOTAL		20,415,450		1,284,791
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 NET ASSETS RELEASED FROM			87,677	
14 TRANSFER TO AFFILIATES	23,080			
15 DEFERRED PENSION COSTS	38,286			
16				
17				
18 TOTAL DEDUCTIONS		61,366		87,677
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		20,354,084		1,197,114

	ENDOWMENT FUND		PLANT FUND	
	5	6	7	8
1 FUND BALANCE AT BEGINNING OF PERIOD				
2 NET INCOME (LOSS)				
3 TOTAL				
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 CONTRIBUTIONS				
6 OTHER RESTRICTED ACTIVITY				
7 GRANT REVENUE				
8 RESTRICTED CONTRIBUTIONS				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL				
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 NET ASSETS RELEASED FROM				
14 TRANSFER TO AFFILIATES				
15 DEFERRED PENSION COSTS				
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 11/30/2010
I	15-1309	I	FROM 7/ 1/2009	I	WORKSHEET G-2
I		I	TO 6/30/2010	I	PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	2,183,115		2,183,115
2 00 SUBPROVIDER			
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
6 00 SKILLED NURSING FACILITY			
7 00 NURSING FACILITY			
7 01 ICF/MR			
8 00 OTHER LONG TERM CARE			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	2,183,115		2,183,115
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT			
11 00 CORONARY CARE UNIT			
12 00 BURN INTENSIVE CARE UNIT			
13 00 SURGICAL INTENSIVE CARE UNIT			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	2,183,115		2,183,115
17 00 ANCILLARY SERVICES	6,140,042	44,173,592	50,313,634
18 00 OUTPATIENT SERVICES			
19 00 HOME HEALTH AGENCY			
20 00 AMBULANCE SERVICES			
21 00 CORF			
22 00 AMBULATORY SURGICAL CENTER (D.P.)			
23 00 HOSPICE			
24 00			
25 00 TOTAL PATIENT REVENUES	8,323,157	44,173,592	52,496,749

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		17,977,408	
ADD (SPECIFY)			
27 00 BAD DEBTS	2,706,114		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		2,706,114	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		20,683,522	

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 11/30/2010
 I 15-1309 I FROM 7/ 1/2009 I WORKSHEET G-3
 I I TO 6/30/2010 I

DESCRIPTION

1	TOTAL PATIENT REVENUES	52,496,749
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	28,775,584
3	NET PATIENT REVENUES	23,721,165
4	LESS: TOTAL OPERATING EXPENSES	20,683,522
5	NET INCOME FROM SERVICE TO PATIENTS	3,037,643
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	
7	INCOME FROM INVESTMENTS	879,916
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	40,937
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	2,199
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	166,308
23	GOVERNMENTAL APPROPRIATIONS	
24	MISC OPERATING INCOME	22,117
24.01	NET ASSETS RELEASED FROM RESTRICTION	20,979
24.02	UNREALIZED GAINS/LOSSES	846,220
25	TOTAL OTHER INCOME	1,978,676
26	TOTAL	5,016,319
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	5,016,319