

**ST. VINCENT JENNINGS HOSPITAL
NORTH VERNON, INDIANA**

PROVIDER NOS. 15-1303, 15-Z303 AND AIM NO. 200360180

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

JUNE 30, 2010

ST. VINCENT JENNINGS HOSPITAL

PROVIDER NOS. 15-1303, 15-Z303 AND AIM NO. 200360180

TABLE OF CONTENTS

Accountants' Disclaimer

Hospital Statements of Reimbursable Costs

Board of Directors
St. Vincent Jennings Hospital
North Vernon, Indiana

We have compiled the Hospital Statements of Reimbursable Costs (Title XVIII and Title XIX) of St. Vincent Jennings 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 financial information 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 information is not designed for those who are not informed about such differences.

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

Bradley Associates, Inc.

November 24, 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 AND SETTLEMENT SUMMARY	I	15-1303	I	FROM 7/ 1/2009	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 6/30/2010	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 11/24/2010 TIME 12:42

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 JENNINGS HOSPITAL 15-1303
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: 11/24/2010 TIME 12:42

VqIf6VeG3zQvRnwnsL9hJtdErPpYf0
tLNyU0Acezd2Yn8ZgLPwIdxdqk24G0
Rmt50IV1j30Rkm44

PI ENCRYPTION INFORMATION
DATE: 11/24/2010 TIME 12:42

jqCdxYQS5Fb1zcJR3n7s9Z1bj0vsx0
:ZMvw0R8:sLx1.Kw3wkVeQzFBuzsCg
G0s84oED6N0:QoPv

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

	TITLE V		TITLE XVIII		TITLE XIX	
	1	A 2	B 3	4		
1	HOSPITAL	0	-10,593	26,913	0	
3	SWING BED - SNF	0	-15,652	0	0	
100	TOTAL	0	-26,245	26,913	0	

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 301 HENRY STREET P.O. BOX:
 1.01 CITY: NORTH VERNON STATE: IN ZIP CODE: 47265- COUNTY: JENNINGS

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N)
02.00	HOSPITAL	15-1303	2.01	7/ 1/1996	V XVIII XIX
04.00	SWING BED - SNF	15-Z303		7/ 5/1991	4 5 6 N 0 N N 0 N

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

18 TYPE OF CONTROL 1 2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
 20 SUBPROVIDER

OTHER INFORMATION

- 21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.
- 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. N
- 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
- 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 Y
- 21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2
- 21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2
- 21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION 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. N
- 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) N N
- 21.08 WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEEDING COST REPORTING PERIOD? ENTER IN COLUMN 2, "Y" FOR YES OR "N" FOR NO.
- 22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N
- 23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N
- 23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. / / / /
- 23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY) / /
- 24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). / /

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

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

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

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

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

25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(b)? ENTER "Y" FOR YES 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 7/ 5/1991

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
28.01	0	0.0000	0.0000	
28.02	0.00	0		

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)

28.03 STAFFING % Y/N

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

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? Y
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 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? Y
42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N
45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000
SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.
45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?
45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?
45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?
46 IF YOU ARE PARTICIPATING IN THE 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: 84,998
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	FEE
	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. N

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL.2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
-----	-----	-----	-----	-----	0.00

SETTLEMENT DATA

63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). Y 6/30/2010

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	TITLE V 3	I/P DAYS / TITLE XVIII 4	O/P VISITS / NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1 ADULTS & PEDIATRICS	25	9,125	24,096.00			647	103
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF						612	
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	25	9,125	24,096.00			1,259	103
6 INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL	25	9,125	24,096.00			1,259	103
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							
24 RURAL HEALTH CLINIC							
25 TOTAL	25						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS						92	
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	TITLE XIX ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	TRIPS TOTAL OBSERVATION BEDS ADMITTED 6.01	TRIPS TOTAL OBSERVATION BEDS NOT ADMITTED 6.02	INTERNS & RES. TOTAL 7	FTES LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			1,004				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			612				
4 ADULTS & PED-SB NF			49				
5 TOTAL ADULTS AND PEDS			1,665				
6 INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL			1,665				
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							
24 RURAL HEALTH CLINIC							
25 TOTAL							
26 OBSERVATION BED DAYS			160	32	128		
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS			5				
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	I & R FTES NET 9	--- FULL TIME EQUIV --- EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	DISCHARGES TITLE V 12	DISCHARGES TITLE XVIII 13	DISCHARGES TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS					211	36	421
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
6 INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL		156.82			211	36	421
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							
24 RURAL HEALTH CLINIC							
25 TOTAL		156.82					

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO:
I 15-1303
I

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

I PREPARED 11/24/2010
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		748,397	748,397	-72,125	676,272
4	0400 NEW CAP REL COSTS-MVBLE EQUIP					
4.01	0401 NEW CAP REL COSTS-MVBLE EQUIP					
5	0500 EMPLOYEE BENEFITS	149,422	2,201,241	2,350,663	-3,026	2,347,637
6	0600 ADMINISTRATIVE & GENERAL	1,162,685	1,580,181	2,742,866	70,771	2,813,637
7	0700 MAINTENANCE & REPAIRS					
8	0800 OPERATION OF PLANT	146,207	686,346	832,553	-7	832,546
9	0900 LAUNDRY & LINEN SERVICE		100,741	100,741		100,741
10	1000 HOUSEKEEPING	251,947	93,258	345,205	-1,086	344,119
11	1100 DIETARY	113,061	72,722	185,783	-133,455	52,328
12	1200 CAFETERIA				132,928	132,928
13	1300 MAINTENANCE OF PERSONNEL					
14	1400 NURSING ADMINISTRATION	174,755	4,716	179,471		179,471
15	1500 CENTRAL SERVICES & SUPPLY	65,015	4,680	69,695	-13	69,682
16	1600 PHARMACY	161,660	546,847	708,507	-172	708,335
17	1700 MEDICAL RECORDS & LIBRARY	818,266	428,405	1,246,671	-387	1,246,284
18	1800 SOCIAL SERVICE					
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	929,786	271,293	1,201,079	-33,250	1,167,829
26	2600 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	358,327	414,606	772,933	-29,217	743,716
38	3800 RECOVERY ROOM					
39	3900 DELIVERY ROOM & LABOR ROOM					
40	4000 ANESTHESIOLOGY					
41	4100 RADIOLOGY-DIAGNOSTIC	861,798	1,276,161	2,137,959	-28,950	2,109,009
42	4200 RADIOLOGY-THERAPEUTIC					
43	4300 RADIOISOTOPE					
44	4400 LABORATORY	595,189	689,548	1,284,737	-24,074	1,260,663
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		22,725	22,725	-5,309	17,416
50	5000 PHYSICAL THERAPY		232,854	232,854	-8,492	224,362
51	5100 OCCUPATIONAL THERAPY		63,181	63,181		63,181
52	5200 SPEECH PATHOLOGY		9,914	9,914		9,914
53	5300 ELECTROCARDIOLOGY		24,318	24,318	10,205	34,523
54	5400 ELECTROENCEPHALOGRAPHY					
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		162,076	162,076	187,518	349,594
55.30	5530 IMPL. DEV. CHARGED TO PATIENT		180,118	180,118		180,118
56	5600 DRUGS CHARGED TO PATIENTS					
57	5700 RENAL DIALYSIS					
58	5800 ASC (NON-DISTINCT PART)					
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC					
61	6100 EMERGENCY	933,078	1,291,721	2,224,799	-61,859	2,162,940
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950 OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310 RURAL HEALTH CLINIC		1,328	1,328		1,328
	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					
70	7000 I&R SERVICES-NOT APPRVD PRGM					
71	7100 HOME HEALTH AGENCY					
	SPEC PURPOSE COST CENTERS					
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	6,721,196	11,107,377	17,828,573	-0-	17,828,573
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
97	9700 RESEARCH					
98	9800 PHYSICIANS' PRIVATE OFFICES					
99	9900 NONPAID WORKERS					
100	7950 OTHER NONREIMBURSABLE COST CENTERS	128,241	12,801	141,042		141,042
100.01	7951 TOBACCO/CHILD GRANT					
100.02	7952 OUTPATIENT CLINICS	8,061	2,076	10,137		10,137
100.03	7953 OTHER NONREIMBURSABLE COST CENTERS					
100.04	7954 SPN					
101	TOTAL	6,857,498	11,122,254	17,979,752	-0-	17,979,752

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSESI PROVIDER NO:
I 15-1303
II PERIOD:
I FROM 7/ 1/2009
I TO 6/30/2010
II PREPARED 11/24/2010
I WORKSHEET A
I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	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	138,613	814,885
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		
4.01	0401 NEW CAP REL COSTS-MVBLE EQUIP		
5	0500 EMPLOYEE BENEFITS	20,930	2,368,567
6	0600 ADMINISTRATIVE & GENERAL	90,941	2,904,578
7	0700 MAINTENANCE & REPAIRS		
8	0800 OPERATION OF PLANT	-14,911	817,635
9	0900 LAUNDRY & LINEN SERVICE		100,741
10	1000 HOUSEKEEPING	75,044	419,163
11	1100 DIETARY	-45,844	6,484
12	1200 CAFETERIA		132,928
13	1300 MAINTENANCE OF PERSONNEL		
14	1400 NURSING ADMINISTRATION		179,471
15	1500 CENTRAL SERVICES & SUPPLY	-9	69,673
16	1600 PHARMACY	-5,444	702,891
17	1700 MEDICAL RECORDS & LIBRARY	-13,682	1,232,602
18	1800 SOCIAL SERVICE		
25	2500 INPAT ROUTINE SRVC CNTRS		
26	2600 ADULTS & PEDIATRICS	-124,500	1,043,329
31	2600 INTENSIVE CARE UNIT		
33	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		
37	3700 ANCILLARY SRVC COST CNTRS		
38	3800 OPERATING ROOM	-38,500	705,216
39	3900 RECOVERY ROOM		
40	3900 DELIVERY ROOM & LABOR ROOM		
41	4000 ANESTHESIOLOGY		
42	4100 RADIOLOGY-DIAGNOSTIC	-3,112	2,105,897
43	4200 RADIOLOGY-THERAPEUTIC		
44	4300 RADIOISOTOPE		
45	4400 LABORATORY	-1,485	1,259,178
46	4500 PBP CLINICAL LAB SERVICES-PRGM ONLY		
47	4600 WHOLE BLOOD & PACKED RED BLOOD CELLS		
48	4700 BLOOD STORING, PROCESSING & TRANS.		
49	4800 INTRAVENOUS THERAPY		
50	4900 RESPIRATORY THERAPY		17,416
51	5000 PHYSICAL THERAPY	-59,075	165,287
52	5100 OCCUPATIONAL THERAPY	-5,957	57,224
53	5200 SPEECH PATHOLOGY		9,914
54	5300 ELECTROCARDIOLOGY	-24,000	10,523
55	5400 ELECTROENCEPHALOGRAPHY		
55.30	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		349,594
56	5530 IMPL. DEV. CHARGED TO PATIENT		180,118
57	5600 DRUGS CHARGED TO PATIENTS		
58	5700 RENAL DIALYSIS		
60	5800 ASC (NON-DISTINCT PART)		
61	6000 OUTPAT SERVICE COST CNTRS		
62	6100 CLINIC		
63	6200 EMERGENCY	-523,249	1,639,691
63.50	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
64	4950 OTHER OUTPATIENT SERVICE COST CENTER		
65	6310 RURAL HEALTH CLINIC	-1,328	
66	6400 OTHER REIMBURS COST CNTRS		
67	6500 HOME PROGRAM DIALYSIS		
68	6600 AMBULANCE SERVICES		
69	6700 DURABLE MEDICAL EQUIP-RENTED		
70	6700 DURABLE MEDICAL EQUIP-SOLD		
71	7000 I&R SERVICES-NOT APPRVD PRGM		
88	7100 HOME HEALTH AGENCY		
89	8800 SPEC PURPOSE COST CENTERS		
90	8900 INTEREST EXPENSE		-0-
91	9000 UTILIZATION REVIEW-SNF		-0-
92	9100 OTHER CAPITAL RELATED COSTS		-0-
93	9200 AMBULATORY SURGICAL CENTER (D.P.)		
94	9300 HOSPICE		
95	9500 SUBTOTALS	-535,568	17,293,005
96	9600 NONREIMBURS COST CENTERS		
97	9700 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9700 RESEARCH		
99	9800 PHYSICIANS' PRIVATE OFFICES		
100	9900 NONPAID WORKERS		
100.01	7950 OTHER NONREIMBURSABLE COST CENTERS		141,042
100.02	7951 TOBACCO/CHILD GRANT		
100.03	7952 OUTPATIENT CLINICS		10,137
100.04	7953 OTHER NONREIMBURSABLE COST CENTERS	267,418	267,418
101	7954 SPN		
	TOTAL	-268,150	17,711,602

COST CENTERS USED IN COST REPORT

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-MVBLE EQUIP	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	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
31	SUBPROVIDER	3100	
33	NURSERY	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	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
64	HOME PROGRAM DIALYSIS	6400	
65	AMBULANCE SERVICES	6500	
66	DURABLE MEDICAL EQUIP-RENTED	6600	
67	DURABLE MEDICAL EQUIP-SOLD	6700	
70	I&R SERVICES-NOT APPRVD PRGM	7000	
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
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		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
97	RESEARCH	9700	
98	PHYSICIANS' PRIVATE OFFICES	9800	
99	NONPAID WORKERS	9900	
100	OTHER NONREIMBURSABLE COST CENTERS	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	TOBACCO/CHILD GRANT	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	OUTPATIENT CLINICS	7952	OTHER NONREIMBURSABLE COST CENTERS
100.03	OTHER NONREIMBURSABLE COST CENTERS	7953	OTHER NONREIMBURSABLE COST CENTERS
100.04	SPN	7954	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151303	FROM 7/ 1/2009	11/24/2010
	TO 6/30/2010	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1)	COST CENTER	LINE NO	SALARY	OTHER
	1	2	3	4	5
1 CAFETERIA	A	CAFETERIA	12	80,895	52,033
2 INTEREST	B	ADMINISTRATIVE & GENERAL	6		72,125
3 ELECTROCARDIOLOGY	G	ELECTROCARDIOLOGY	53	10,205	
4 MEDICAL SUPPLIES CHARGED TO PATIENTS	J	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		187,518
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
36 TOTAL RECLASSIFICATIONS				91,100	311,676

(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:
151303

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

PREPARED 11/24/2010
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 6	DECREASE		SALARY 8	OTHER 9	A-7 REF 10
			LINE NO 7				
1 CAFETERIA	A	DIETARY	11		80,895	52,033	
2 INTEREST	B	NEW CAP REL COSTS-BLDG & FIXT	3			72,125	9
3 ELECTROCARDIOLOGY	G	LABORATORY	44		10,205		
4 MEDICAL SUPPLIES CHARGED TO PATIENTS	J	HOUSEKEEPING	10			1,086	
5		DIETARY	11			527	
6		OPERATION OF PLANT	8			7	
7		CENTRAL SERVICES & SUPPLY	15			13	
8		PHARMACY	16			172	
9		MEDICAL RECORDS & LIBRARY	17			387	
10		ADULTS & PEDIATRICS	25			33,250	
11		OPERATING ROOM	37			29,217	
12		RADIOLOGY-DIAGNOSTIC	41			28,950	
13		LABORATORY	44			13,869	
14		RESPIRATORY THERAPY	49			5,309	
15		PHYSICAL THERAPY	50			8,492	
16		ADMINISTRATIVE & GENERAL	6			1,354	
17		EMPLOYEE BENEFITS	5			3,026	
18		EMERGENCY	61			61,859	
36 TOTAL RECLASSIFICATIONS					91,100	311,676	

(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
151303	FROM 7/ 1/2009	11/24/2010
	TO 6/30/2010	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : CAFETERIA

----- INCREASE -----		
LINE	COST CENTER	AMOUNT
1.00	CAFETERIA	132,928
TOTAL RECLASSIFICATIONS FOR CODE A		132,928

----- DECREASE -----		
COST CENTER	LINE	AMOUNT
DIETARY	11	132,928
		132,928

RECLASS CODE: B
EXPLANATION : INTEREST

----- INCREASE -----		
LINE	COST CENTER	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	72,125
TOTAL RECLASSIFICATIONS FOR CODE B		72,125

----- DECREASE -----		
COST CENTER	LINE	AMOUNT
NEW CAP REL COSTS-BLDG & FIXT	3	72,125
		72,125

RECLASS CODE: G
EXPLANATION : ELECTROCARDIOLOGY

----- INCREASE -----		
LINE	COST CENTER	AMOUNT
1.00	ELECTROCARDIOLOGY	10,205
TOTAL RECLASSIFICATIONS FOR CODE G		10,205

----- DECREASE -----		
COST CENTER	LINE	AMOUNT
LABORATORY	44	10,205
		10,205

RECLASS CODE: J
EXPLANATION : MEDICAL SUPPLIES CHARGED TO PATIENTS

----- INCREASE -----		
LINE	COST CENTER	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	187,518
2.00		0
3.00		0
4.00		0
5.00		0
6.00		0
7.00		0
8.00		0
9.00		0
10.00		0
11.00		0
12.00		0
13.00		0
14.00		0
15.00		0
TOTAL RECLASSIFICATIONS FOR CODE J		187,518

----- DECREASE -----		
COST CENTER	LINE	AMOUNT
HOUSEKEEPING	10	1,086
DIETARY	11	527
OPERATION OF PLANT	8	7
CENTRAL SERVICES & SUPPLY	15	13
PHARMACY	16	172
MEDICAL RECORDS & LIBRARY	17	387
ADULTS & PEDIATRICS	25	33,250
OPERATING ROOM	37	29,217
RADIOLOGY-DIAGNOSTIC	41	28,950
LABORATORY	44	13,869
RESPIRATORY THERAPY	49	5,309
PHYSICAL THERAPY	50	8,492
ADMINISTRATIVE & GENERAL	6	1,354
EMPLOYEE BENEFITS	5	3,026
EMERGENCY	61	61,859
		187,518

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	127,944						127,944	
2 LAND IMPROVEMENTS	400,829						400,829	
3 BUILDINGS & FIXTURE	13,474,902	23,430			23,430		13,498,332	
4 BUILDING IMPROVEMEN								
5 FIXED EQUIPMENT	4,251,144					142,425	4,108,719	
6 MOVABLE EQUIPMENT								
7 SUBTOTAL	18,254,819	23,430			23,430	142,425	18,135,824	
8 RECONCILING ITEMS								
9 TOTAL	18,254,819	23,430			23,430	142,425	18,135,824	

PART III - RECONCILIATION OF CAPITAL COST CENTERS
 DESCRIPTION

*	DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL	
		GROSS ASSETS	CAPITIALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES		OTHER CAPITAL RELATED COSTS
		1	2	3	4	5	6	7	8
1	OLD CAP REL COSTS-BL								
2	OLD CAP REL COSTS-MV								
3	NEW CAP REL COSTS-BL	18,135,824		18,135,824	1.000000				
4	NEW CAP REL COSTS-MV								
4 01	NEW CAP REL COSTS-MV								
5	TOTAL	18,135,824		18,135,824	1.000000				

DESCRIPTION

SUMMARY OF OLD AND NEW CAPITAL

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
		9	10	11	12	13	14	15
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	814,885						814,885
4	NEW CAP REL COSTS-MV							
4 01	NEW CAP REL COSTS-MV							
5	TOTAL	814,885						814,885

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

SUMMARY OF OLD AND NEW CAPITAL

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
		9	10	11	12	13	14	15
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	748,397						748,397
4	NEW CAP REL COSTS-MV							
4 01	NEW CAP REL COSTS-MV							
5	TOTAL	748,397						748,397

* All lines numbers except line 5 are to be consistent with workshseet 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

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST. A-7 REF. 5
			COST CENTER	LINE NO	
	1	2	3	4	5
1 INVST INCOME-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			OLD CAP REL COSTS-MVBLE E	2	
3 INVST INCOME-NEW BLDGS AND FIXTURES	A	-13,161	NEW CAP REL COSTS-BLDG &	3	9
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5 INVESTMENT INCOME-OTHER	A	-3,164	ADMINISTRATIVE & GENERAL	6	
6 TRADE, QUANTITY AND TIME DISCOUNTS					
7 REFUNDS AND REBATES OF EXPENSES					
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9 TELEPHONE SERVICES					
10 TELEVISION AND RADIO SERVICE	A	-4,845	OPERATION OF PLANT	8	
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-817,360			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1	553,722			
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-27,788	DIETARY	11	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS					
18 SALE OF MED AND SURG SUPPLIES					
19 SALE OF DRUGS TO OTHER THAN PATIENTS					
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-13,682	MEDICAL RECORDS & LIBRARY	17	
21 NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22 VENDING MACHINES					
23 INCOME FROM IMPOSITION OF INTEREST					
24 INTRST EXP ON MEDICARE OVERPAYMENTS					
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4	-59,075	PHYSICAL THERAPY	50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28 UTILIZATION REVIEW-PHYSIAN COMP			UTILIZATION REVIEW-SNF	89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1	
30 DEPRECIATION-OLD MOVABLE EQUIP			OLD CAP REL COSTS-MVBLE E	2	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34 PHYSICIANS' ASSISTANT					
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4	-5,957	OCCUPATIONAL THERAPY	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
37 PATIENT PHONE BENEFITS	A	-693	EMPLOYEE BENEFITS	5	
38 PATIENT PHONE DEPRECIATION	A	-731	NEW CAP REL COSTS-BLDG &	3	9
39 PATIENT PHONE OPERATING COSTS	A	-2,563	ADMINISTRATIVE & GENERAL	6	
40 PHYSICIAN BENEFITS	A	-4,332	EMPLOYEE BENEFITS	5	
41 PHYSICIAN HOUSEKEEPING	A	-17,260	HOUSEKEEPING	10	
42 PHYSICIAN PLANT OPS	A	-9,991	OPERATION OF PLANT	8	
43 PHYSICIAN FEE ACCRUAL	A	93,425	EMERGENCY	61	
44 AHA & IHA DUES	A	-965	ADMINISTRATIVE & GENERAL	6	
45					
46 LOSS ON FIXED ASSETS	A	-852	NEW CAP REL COSTS-BLDG &	3	9
47 MISC	B	-7,351	EMPLOYEE BENEFITS	5	
48 MISC	B	-555	ADMINISTRATIVE & GENERAL	6	
49 MISC	B	-18,056	DIETARY	11	
49.01 MISC	B	-1,485	LABORATORY	44	
49.02 MISC	B	-1,022	ADMINISTRATIVE & GENERAL	6	
49.03 RHC DEPRECIATION	A	-1,328	RURAL HEALTH CLINIC	63.50	
49.04 SPN HOUSEKEEPING	A	92,304	HOUSEKEEPING	10	
49.05 CHARITABLE EXPENSE	A	-9	CENTRAL SERVICES & SUPPLY	15	
49.06 CHARITABLE EXPENSE	A	-5,444	PHARMACY	16	
49.07 CHARITABLE EXPENSE	A	-240	EMPLOYEE BENEFITS	5	
49.08 CHARITABLE EXPENSE	A	-1,465	EMERGENCY	61	
49.09 CHARITABLE EXPENSE	A	-9,002	ADMINISTRATIVE & GENERAL	6	
49.10 CHARITABLE EXPENSE	A	-75	OPERATION OF PLANT	8	
49.11 SERVICING FEES	A	20,850	ADMINISTRATIVE & GENERAL	6	
50 TOTAL (SUM OF LINES 1 THRU 49)		-268,150			

(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	230,757		230,757	9
2	6	ADMINISTRATIVE & GENERAL HOME OFFICE	1,480,679	1,328,748	151,931	
3	100	3 OTHER NONREIMBURSABLE COS HOME OFFICE	267,418		267,418	
4	17	MEDICAL RECORDS & LIBRARY ST. VINCENT HEALTH - CHAR	660,348	660,348		
4.01	41	RADIOLOGY-DIAGNOSTIC ST. VINCENT HEALTH - CHAR	12,603	12,603		
4.02	44	LABORATORY ST. VINCENT HEALTH - CHAR	12,504	12,504		
4.03	5	EMPLOYEE BENEFITS ST. VINCENT HEALTH - CHAR	298,116	298,116		
4.04	3	NEW CAP REL COSTS-BLDG & ASCENSION - CHARGEBACK	14,088	14,088		9
4.05	6	ADMINISTRATIVE & GENERAL ST. VINCENT HEALTH - CHAR	410,527	410,527		
4.06	3	NEW CAP REL COSTS-BLDG & ASCENSION - INTEREST	176,645	254,045	-77,400	9
4.07	8	OPERATION OF PLANT ST. VINCENT HEALTH - CHAR	8,363	8,363		
4.08	6	ADMINISTRATIVE & GENERAL ASCENSION - INTEREST	42,471	61,080	-18,609	
4.09	5	EMPLOYEE BENEFITS ASCENSION - PENSION	287,253	287,253		
4.10	6	ADMINISTRATIVE & GENERAL ASCENSION - CHARGEBACK	87,068	87,068		
4.11	6	ADMINISTRATIVE & GENERAL ASCENSION - CHARGEBACK	416,858	450,779	-33,921	
4.12	5	EMPLOYEE BENEFITS SELF INSURANCE	937,543	903,997	33,546	
4.13	16	PHARMACY ST. VINCENT HEALTH - CHAR	3,456	3,456		
4.14	61	EMERGENCY ST. VINCENT HEALTH - CHAR	44,098	44,098		
4.15						
4.16						
4.17						
4.18						
5		TOTALS	5,390,795	4,837,073	553,722	

* 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	ASCENSION	100.00	ASCENSION	100.00	ADMINISTRATION
3	B	ST. VINCENT HOSPITAL	100.00	ST. VINCENT HOSPITAL	100.00	HOSPITAL
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 PERIOD: I PREPARED 11/24/2010
 I 15-1303 I FROM 7/ 1/2009 I WORKSHEET A-8-2
 I I TO 6/30/2010 I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1 25	A&P	124,500	124,500					
2 37	OR	38,500	38,500					
3 41	RADIOLOGY	3,112	3,112					
4 53	EKG	24,000	24,000					
5 61	ER PHYSICIAN	1,180,371	615,209	565,162				
6 6	ADMINISTRATION	12,039	12,039					
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	1,382,522	817,360	565,162				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I 15-1303 I

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

I PREPARED 11/24/2010 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 25	A&P							124,500
2 37	OR							38,500
3 41	RADIOLOGY							3,112
4 53	EKG							24,000
5 61	ER PHYSICIAN							615,209
6 6	ADMINISTRATION							12,039
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							817,360

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

I PROVIDER NO: I 15-1303
 I

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

I PREPARED 11/24/2010
 I WORKSHEET A-8-4
 I PARTS I - VII

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	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)	154
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	99
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		319.00	2245.00	76.00
10	AHSEA (SEE INSTRUCTIONS)		68.36	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)	34.18	34.18	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)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	21,807
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	119,187
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	140,994
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	3,586
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)	144,580

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)	144,580

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)	5,264
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	2,628
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	7,892
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	1,419
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	9,311
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) 9,311
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 144,580
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 9,311
 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) 153,891
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 212,966

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

I PROVIDER NO: I 15-1303 I

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

I PREPARED 11/24/2010 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS) 59,075

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

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS) 212,966
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) 212,966
68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67) 1.000000
68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)
68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)
69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS) 59,075
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) 59,075

OCCUPATIONAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	174
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
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		522.00	43.00	17.00
10	AHSEA (SEE INSTRUCTIONS)		64.81	50.33	44.74
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	32.41	32.41	25.17	
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)	33,831
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	2,164
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	35,995
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	761
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)	36,756

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	63.71
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	49,694
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	50,455

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)	5,639
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	126
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	5,765
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	1,004
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	6,769

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)	

OCCUPATIONAL THERAPY

33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 6,769
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 50,455
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 6,769
 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) 57,224
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 63,181

OCCUPATIONAL THERAPY

65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF 5,957
 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 - 63,181
 (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 63,181
 LINE MUST AGREE WITH LINE 64)
 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- 5,957
 (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 5,957
 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE
 WITH LINE 65)

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)	29
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	5.61
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5
9	TOTAL HOURS WORKED		39.00	1.00	
10	AHSEA (SEE INSTRUCTIONS)		62.29	43.00	
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	31.15	31.15		
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)	2,429
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)	2,429
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	43
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)	2,472

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)	62.28
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	48,578
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	48,621

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)	903
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	903
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	163
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	1,066
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)	

SPEECH PATHOLOGY

33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 1,066
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 48,621
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 1,066
 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) 49,687
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 9,914

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 - 9,914
 (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) 9,914
 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 11/24/2010
 I 15-1303 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	DOLLAR	VALUE	ENTERED
4.01	NEW CAP REL COSTS-MVBLE EQUIP	1	SQUARE	FEET	NOT 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	3	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	ITEMIZED	BILLS	ENTERED
10	HOUSEKEEPING	9	HOURS OF	SERVICE	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	11	HOURS		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	GROSS CHARGES		ENTERED
18	SOCIAL SERVICE	17	TIME	SPENT	NOT ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	OLD CAP REL C OSTs-BLDG & 1	OLD CAP REL C OSTs-MVBLE E 2	NEW CAP REL C OSTs-BLDG & 3	NEW CAP REL C OSTs-MVBLE E 4	NEW CAP REL C OSTs-MVBLE E 4.01	EMPLOYEE BENE FITS 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 &	814,885			814,885			
004 01 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS	2,368,567						2,368,567
006 ADMINISTRATIVE & GENERAL	2,904,578			71,990			410,535
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT	817,635			74,390			51,625
009 LAUNDRY & LINEN SERVICE	100,741			885			
010 HOUSEKEEPING	419,163			16,725			88,960
011 DIETARY	6,484			8,246			11,358
012 CAFETERIA	132,928			16,993			28,563
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION	179,471			1,933			61,705
015 CENTRAL SERVICES & SUPPLY	69,673			13,557			22,956
016 PHARMACY	702,891			7,629			57,081
017 MEDICAL RECORDS & LIBRARY	1,232,602			64,536			288,923
018 SOCIAL SERVICE							
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	1,043,329			76,451			328,300
031 INTENSIVE CARE UNIT							
033 SUBPROVIDER							
034 NURSERY							
035 SKILLED NURSING FACILITY							
035 01 NURSING FACILITY							
036 ICF/MR							
037 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM	705,216			60,751			126,522
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	2,105,897			49,232			304,294
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY	1,259,178			18,216			206,553
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	17,416						
050 PHYSICAL THERAPY	165,287			19,707			
051 OCCUPATIONAL THERAPY	57,224						
052 SPEECH PATHOLOGY	9,914						
053 ELECTROCARDIOLOGY	10,523			2,318			3,603
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED	349,594						
055 30 IMPL. DEV. CHARGED TO PAT	180,118						
056 DRUGS CHARGED TO PATIENTS							
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
061 EMERGENCY	1,639,691			49,174			329,462
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC							
064 OTHER REIMBURS COST CNTRS							
065 HOME PROGRAM DIALYSIS							
066 AMBULANCE SERVICES							
067 DURABLE MEDICAL EQUIP-REN							
067 DURABLE MEDICAL EQUIP-SOL							
070 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
092 SPEC PURPOSE COST CENTERS							
093 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	17,293,005			552,733			2,320,440
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP				4,216			
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC				9,213			
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS	141,042						45,281
100 01 TOBACCO/CHILD GRANT							
100 02 OUTPATIENT CLINICS	10,137			86,654			2,846
100 03 OTHER NONREIMBURSABLE COS	267,418						
100 04 SPN				162,069			
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	17,711,602			814,885			2,368,567

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1303 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
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 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL	3,387,103	3,387,103					
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT	943,650	223,131		1,166,781			
009 LAUNDRY & LINEN SERVICE	101,626	24,030		1,545	127,201		
010 HOUSEKEEPING	524,848	124,103		29,191	33,672	711,814	
011 DIETARY	26,088	6,169		14,392		26,122	72,771
012 CAFETERIA	178,484	42,203		29,659	3,705		
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION	243,109	57,484		3,374			
015 CENTRAL SERVICES & SUPPLY	106,186	25,108		23,662			
016 PHARMACY	767,601	181,503		13,315		4,665	
017 MEDICAL RECORDS & LIBRARY	1,586,061	375,032		112,639		6,219	
018 SOCIAL SERVICE							
025 INPAT ROUTINE SRVC CNTRS	1,448,080	342,406		133,435	14,964	121,901	72,771
026 ADULTS & PEDIATRICS							
031 INTENSIVE CARE UNIT							
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	892,489	211,033		106,032	36,364	74,633	
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	2,459,423	581,547		85,928	11,320	47,268	
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY	1,483,947	350,887		31,793	1,611	29,853	
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	17,416	4,118					
050 PHYSICAL THERAPY	184,994	43,743		34,395	6,644	9,329	
051 OCCUPATIONAL THERAPY	57,224	13,531					
052 SPEECH PATHOLOGY	9,914	2,344					
053 ELECTROCARDIOLOGY	16,444	3,888		4,045			
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED	349,594	82,663					
055 30 IMPL. DEV. CHARGED TO PAT	180,118	42,590					
056 DRUGS CHARGED TO PATIENTS							
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
061 EMERGENCY	2,018,327	477,244		85,826	15,615	87,072	
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC							
064 OTHER REIMBURS COST CNTRS							
065 HOME PROGRAM DIALYSIS							
065 AMBULANCE SERVICES							
066 DURABLE MEDICAL EQUIP-REN							
067 DURABLE MEDICAL EQUIP-SOL							
070 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
092 SPEC PURPOSE COST CENTERS							
093 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	16,982,726	3,214,757		709,231	123,895	407,062	72,771
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP	4,216	997		7,359			
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC	9,213	2,178		16,080			
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS	186,323	44,057				12,439	
100 01 TOBACCO/CHILD GRANT							
100 02 OUTPATIENT CLINICS	99,637	23,560		151,242	3,306	31,097	
100 03 OTHER NONREIMBURSABLE COS	267,418	63,232					
100 04 SPN	162,069	38,322		282,869		261,216	
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	17,711,602	3,387,103		1,166,781	127,201	711,814	72,771

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1303 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART I

COST CENTER DESCRIPTION	CAFETERIA	MAINTENANCE O NURSING ADMIN CENTRAL SERVI PHARMACY	MEDICAL RECOR SOCIAL SERVIC
	12	F PERSONNEL ISTRATION CES & SUPPLY	DS & LIBRARY E
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 EMPLOYEE BENEFITS			
006 ADMINISTRATIVE & GENERAL			
007 MAINTENANCE & REPAIRS			
008 OPERATION OF PLANT			
009 LAUNDRY & LINEN SERVICE			
010 HOUSEKEEPING			
011 DIETARY			
012 CAFETERIA	254,051		
013 MAINTENANCE OF PERSONNEL			
014 NURSING ADMINISTRATION	4,217	308,184	
015 CENTRAL SERVICES & SUPPLY	4,519		159,475
016 PHARMACY	4,944		78
017 MEDICAL RECORDS & LIBRARY	37,937		176
018 SOCIAL SERVICE			
025 INPAT ROUTINE SRVC CNTRS			
026 ADULTS & PEDIATRICS	42,752	154,092	15,116
031 INTENSIVE CARE UNIT			
033 SUBPROVIDER			
034 NURSERY			
035 SKILLED NURSING FACILITY			
035 01 NURSING FACILITY			
036 ICF/MR			
037 OTHER LONG TERM CARE			
038 ANCILLARY SRVC COST CNTRS			
039 OPERATING ROOM	16,829	37,195	13,282
040 RECOVERY ROOM			
041 DELIVERY ROOM & LABOR ROO			
042 ANESTHESIOLOGY			
043 RADIOLOGY-DIAGNOSTIC	35,818	39,851	13,161
044 RADIOLOGY-THERAPEUTIC			
045 RADIOISOTOPE			
046 LABORATORY	31,805	31,881	6,305
047 PBP CLINICAL LAB SERVICES			
048 WHOLE BLOOD & PACKED RED			
049 BLOOD STORING, PROCESSING			
050 INTRAVENOUS THERAPY			
051 RESPIRATORY THERAPY			2,414
052 PHYSICAL THERAPY			3,861
053 OCCUPATIONAL THERAPY			
054 SPEECH PATHOLOGY			
055 ELECTROCARDIOLOGY			
054 ELECTROENCEPHALOGRAPHY			
055 MEDICAL SUPPLIES CHARGED			76,291
055 30 IMPL. DEV. CHARGED TO PAT			
056 DRUGS CHARGED TO PATIENTS			
057 RENAL DIALYSIS			972,106
058 ASC (NON-DISTINCT PART)			
060 OUTPAT SERVICE COST CNTRS			
061 CLINIC			
062 EMERGENCY	37,774	45,165	28,122
063 OBSERVATION BEDS (NON-DIS			
063 OTHER OUTPATIENT SERVICE			
063 50 RURAL HEALTH CLINIC			
064 OTHER REIMBURS COST CNTRS			
065 HOME PROGRAM DIALYSIS			
066 AMBULANCE SERVICES			
067 DURABLE MEDICAL EQUIP-REN			
070 DURABLE MEDICAL EQUIP-SOL			
071 I&R SERVICES-NOT APPRVD P			
092 HOME HEALTH AGENCY			
093 SPEC PURPOSE COST CENTERS			
095 AMBULATORY SURGICAL CENTE			
096 HOSPICE			
095 SUBTOTALS	216,595	308,184	158,806
096 NONREIMBURS COST CENTERS			
097 GIFT, FLOWER, COFFEE SHOP			
098 RESEARCH			
099 PHYSICIANS' PRIVATE OFFIC			
100 NONPAID WORKERS			
100 OTHER NONREIMBURSABLE COS	8,895		412
100 01 TOBACCO/CHILD GRANT			
100 02 OUTPATIENT CLINICS	702		257
100 03 OTHER NONREIMBURSABLE COS			
100 04 SPN	27,859		
101 CROSS FOOT ADJUSTMENT			
102 NEGATIVE COST CENTER			
103 TOTAL	254,051	308,184	159,475
			972,106
			2,118,064

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	25	26	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-MVBLE E			
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			
INPAT ROUTINE SRVC CNTRS			
025 ADULTS & PEDIATRICS	2,421,408		2,421,408
026 INTENSIVE CARE UNIT			
031 SUBPROVIDER			
033 NURSERY			
034 SKILLED NURSING FACILITY			
035 NURSING FACILITY			
035 01 ICF/MR			
036 OTHER LONG TERM CARE			
ANCILLARY SRVC COST CNTRS			
037 OPERATING ROOM	1,601,099		1,601,099
038 RECOVERY ROOM			
039 DELIVERY ROOM & LABOR ROO			
040 ANESTHESIOLOGY			
041 RADIOLOGY-DIAGNOSTIC	3,922,997		3,922,997
042 RADIOLOGY-THERAPEUTIC			
043 RADIOISOTOPE			
044 LABORATORY	2,451,260		2,451,260
045 PBP CLINICAL LAB SERVICES			
046 WHOLE BLOOD & PACKED RED			
047 BLOOD STORING, PROCESSING			
048 INTRAVENOUS THERAPY			
049 RESPIRATORY THERAPY	33,415		33,415
050 PHYSICAL THERAPY	341,696		341,696
051 OCCUPATIONAL THERAPY	87,340		87,340
052 SPEECH PATHOLOGY	12,807		12,807
053 ELECTROCARDIOLOGY	42,396		42,396
054 ELECTROENCEPHALOGRAPHY			
055 MEDICAL SUPPLIES CHARGED	577,156		577,156
055 30 IMPL. DEV. CHARGED TO PAT	242,043		242,043
056 DRUGS CHARGED TO PATIENTS	1,105,693		1,105,693
057 RENAL DIALYSIS			
058 ASC (NON-DISTINCT PART)			
OUTPAT SERVICE COST CNTRS			
060 CLINIC			
061 EMERGENCY	3,167,337		3,167,337
062 OBSERVATION BEDS (NON-DIS			
063 OTHER OUTPATIENT SERVICE			
063 50 RURAL HEALTH CLINIC			
OTHER REIMBURS COST CNTRS			
064 HOME PROGRAM DIALYSIS			
065 AMBULANCE SERVICES			
066 DURABLE MEDICAL EQUIP-REN			
067 DURABLE MEDICAL EQUIP-SOL			
070 I&R SERVICES-NOT APPRVD P			
071 HOME HEALTH AGENCY			
SPEC PURPOSE COST CENTERS			
092 AMBULATORY SURGICAL CENTE			
093 HOSPICE			
095 SUBTOTALS	16,006,647		16,006,647
NONREIMBURS COST CENTERS			
096 GIFT, FLOWER, COFFEE SHOP	12,572		12,572
097 RESEARCH			
098 PHYSICIANS' PRIVATE OFFIC	27,471		27,471
099 NONPAID WORKERS			
100 OTHER NONREIMBURSABLE COS	252,126		252,126
100 01 TOBACCO/CHILD GRANT			
100 02 OUTPATIENT CLINICS	309,801		309,801
100 03 OTHER NONREIMBURSABLE COS	330,650		330,650
100 04 SPN	772,335		772,335
101 CROSS FOOT ADJUSTMENT			
102 NEGATIVE COST CENTER			
103 TOTAL	17,711,602		17,711,602

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	DIR ASSIGNED	OLD CAP REL C	OLD CAP REL C	NEW CAP REL C	NEW CAP REL C	NEW CAP REL C	SUBTOTAL
	NEW CAPITAL REL COSTS	OSTS-BLDG & 1	OSTS-MVBLE E 2	OSTS-BLDG & 3	OSTS-MVBLE E 4	OSTS-MVBLE E 4.01	
	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							
005 EMPLOYEE BENEFITS	1,947						1,947
006 ADMINISTRATIVE & GENERAL	8,219			71,990			80,209
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT	38,979			74,390			113,369
009 LAUNDRY & LINEN SERVICE				885			885
010 HOUSEKEEPING	2,258			16,725			18,983
011 DIETARY	1,993			8,246			10,239
012 CAFETERIA				16,993			16,993
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION				1,933			1,933
015 CENTRAL SERVICES & SUPPLY	319			13,557			13,876
016 PHARMACY	1,774			7,629			9,403
017 MEDICAL RECORDS & LIBRARY	1,467			64,536			66,003
018 SOCIAL SERVICE							
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	21,336			76,451			97,787
031 INTENSIVE CARE UNIT							
033 SUBPROVIDER							
034 NURSERY							
035 SKILLED NURSING FACILITY							
035 01 NURSING FACILITY							
036 ICF/MR							
037 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM	57,346			60,751			118,097
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	62,076			49,232			111,308
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY	21,838			18,216			40,054
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY							
050 PHYSICAL THERAPY	2,751			19,707			22,458
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY							
053 ELECTROCARDIOLOGY	318			2,318			2,636
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							
061 CLINIC							
061 EMERGENCY	9,098			49,174			58,272
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC							
064 OTHER REIMBURS COST CNTRS							
065 HOME PROGRAM DIALYSIS							
066 AMBULANCE SERVICES							
066 DURABLE MEDICAL EQUIP-REN							
067 DURABLE MEDICAL EQUIP-SOL							
070 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
092 SPEC PURPOSE COST CENTERS							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	231,719			552,733			784,452
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP				4,216			4,216
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC				9,213			9,213
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS							
100 01 TOBACCO/CHILD GRANT							
100 02 OUTPATIENT CLINICS	556			86,654			87,210
100 03 OTHER NONREIMBURSABLE COS							
100 04 SPN				162,069			162,069
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	232,275			814,885			1,047,160

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	EMPLOYEE BENE	ADMINISTRATIV	MAINTENANCE & OPERATION OF	LAUNDRY & LIN	HOUSEKEEPING	DIETARY	
	FITS	E & GENERAL	REPAIRS	EN SERVICE			
	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							
005 EMPLOYEE BENEFITS	1,947						
006 ADMINISTRATIVE & GENERAL	339	80,548					
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT	42	5,306		118,717			
009 LAUNDRY & LINEN SERVICE				157	1,613		
010 HOUSEKEEPING	73	2,951		2,970	427	25,404	
011 DIETARY	9	147		1,464		932	12,791
012 CAFETERIA	23	1,004		3,018	47		
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION	51	1,367		343			
015 CENTRAL SERVICES & SUPPLY	19	597		2,408			
016 PHARMACY	47	4,316		1,355		166	
017 MEDICAL RECORDS & LIBRARY	237	8,918		11,461		222	
018 SOCIAL SERVICE							
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	270	8,143		13,577	190	4,351	12,791
031 INTENSIVE CARE UNIT							
033 SUBPROVIDER							
034 NURSERY							
035 SKILLED NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM	104	5,018		10,789	461	2,664	
039 RECOVERY ROOM							
040 DELIVERY ROOM & LABOR ROO							
041 ANESTHESIOLOGY							
042 RADIOLOGY-DIAGNOSTIC	250	13,831		8,743	144	1,687	
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
045 LABORATORY	170	8,344		3,235	20	1,065	
046 PBP CLINICAL LAB SERVICES							
047 WHOLE BLOOD & PACKED RED							
048 BLOOD STORING, PROCESSING							
049 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY		98					
050 PHYSICAL THERAPY		1,040		3,500	84	333	
051 OCCUPATIONAL THERAPY		322					
052 SPEECH PATHOLOGY		56					
053 ELECTROCARDIOLOGY	3	92		412			
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED		1,966					
055 30 IMPL. DEV. CHARGED TO PAT		1,013					
056 DRUGS CHARGED TO PATIENTS							
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
061 EMERGENCY	271	11,349		8,733	198	3,108	
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC							
064 OTHER REIMBURS COST CNTRS							
065 HOME PROGRAM DIALYSIS							
066 AMBULANCE SERVICES							
067 DURABLE MEDICAL EQUIP-REN							
067 DURABLE MEDICAL EQUIP-SOL							
070 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
092 SPEC PURPOSE COST CENTERS							
093 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	1,908	76,449		72,165	1,571	14,528	12,791
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP		24		749			
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC		52		1,636			
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS	37	1,048				444	
100 01 TOBACCO/CHILD GRANT							
100 02 OUTPATIENT CLINICS	2	560		15,389	42	1,110	
100 03 OTHER NONREIMBURSABLE COS		1,504					
100 04 SPN		911		28,778		9,322	
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	1,947	80,548		118,717	1,613	25,404	12,791

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	CAFETERIA 12	MAINTENANCE O PERSONNEL 13	NURSING ADMINISTRATION 14	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 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 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING							
011 DIETARY							
012 CAFETERIA	21,085						
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION	350		4,044				
015 CENTRAL SERVICES & SUPPLY	375			17,275			
016 PHARMACY	410			8	15,705		
017 MEDICAL RECORDS & LIBRARY	3,149			19		90,009	
018 SOCIAL SERVICE							
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	3,548		2,022	1,637		3,225	
031 INTENSIVE CARE UNIT							
033 SUBPROVIDER							
034 NURSERY							
035 SKILLED NURSING FACILITY							
035 01 NURSING FACILITY							
036 ICF/MR							
037 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM	1,397		488	1,439		9,061	
039 RECOVERY ROOM							
040 DELIVERY ROOM & LABOR ROO							
041 ANESTHESIOLOGY							
042 RADIOLOGY-DIAGNOSTIC	2,973		523	1,426		27,569	
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
044 LABORATORY	2,640		418	683		20,532	
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY				261		402	
050 PHYSICAL THERAPY				418		2,496	
051 OCCUPATIONAL THERAPY						705	
052 SPEECH PATHOLOGY						23	
053 ELECTROCARDIOLOGY						766	
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED				8,265		2,915	
056 30 IMPL. DEV. CHARGED TO PAT						822	
057 DRUGS CHARGED TO PATIENTS					15,705	5,677	
058 RENAL DIALYSIS							
060 ASC (NON-DISTINCT PART)							
061 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
061 EMERGENCY	3,135		593	3,046		15,816	
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC							
064 OTHER REIMBURS COST CNTRS							
065 HOME PROGRAM DIALYSIS							
066 AMBULANCE SERVICES							
067 DURABLE MEDICAL EQUIP-REN							
070 DURABLE MEDICAL EQUIP-SOL							
071 I&R SERVICES-NOT APPRVD P							
092 HOME HEALTH AGENCY							
093 SPEC PURPOSE COST CENTERS							
095 AMBULATORY SURGICAL CENTE							
096 HOSPICE							
095 SUBTOTALS	17,977		4,044	17,202	15,705	90,009	
096 NONREIMBURS COST CENTERS							
097 GIFT, FLOWER, COFFEE SHOP							
098 RESEARCH							
099 PHYSICIANS' PRIVATE OFFIC							
100 NONPAID WORKERS							
100 01 OTHER NONREIMBURSABLE COS	738			45			
100 02 TOBACCO/CHILD GRANT							
100 03 OUTPATIENT CLINICS	58			28			
100 04 OTHER NONREIMBURSABLE COS							
101 SPN	2,312						
102 CROSS FOOT ADJUSTMENTS							
103 NEGATIVE COST CENTER							
103 TOTAL	21,085		4,044	17,275	15,705	90,009	

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO:

I PERIOD:

I PREPARED 11/24/2010

I 15-1303

I FROM 7/ 1/2009

I WORKSHEET B

I

I TO 6/30/2010

I PART III

		SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	COST CENTER DESCRIPTION	25	26	27
	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-MVBLE E			
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			
	INPAT ROUTINE SRVC CNTRS			
025	ADULTS & PEDIATRICS	147,541		147,541
026	INTENSIVE CARE UNIT			
031	SUBPROVIDER			
033	NURSERY			
034	SKILLED NURSING FACILITY			
035	NURSING FACILITY			
035 01	ICF/MR			
036	OTHER LONG TERM CARE			
	ANCILLARY SRVC COST CNTRS			
037	OPERATING ROOM	149,518		149,518
038	RECOVERY ROOM			
039	DELIVERY ROOM & LABOR ROO			
040	ANESTHESIOLOGY			
041	RADIOLOGY-DIAGNOSTIC	168,454		168,454
042	RADIOLOGY-THERAPEUTIC			
043	RADIOISOTOPE			
044	LABORATORY	77,161		77,161
045	PBP CLINICAL LAB SERVICES			
046	WHOLE BLOOD & PACKED RED			
047	BLOOD STORING, PROCESSING			
048	INTRAVENOUS THERAPY			
049	RESPIRATORY THERAPY	761		761
050	PHYSICAL THERAPY	30,329		30,329
051	OCCUPATIONAL THERAPY	1,027		1,027
052	SPEECH PATHOLOGY	79		79
053	ELECTROCARDIOLOGY	3,909		3,909
054	ELECTROENCEPHALOGRAPHY			
055	MEDICAL SUPPLIES CHARGED	13,146		13,146
055 30	IMPL. DEV. CHARGED TO PAT	1,835		1,835
056	DRUGS CHARGED TO PATIENTS	21,382		21,382
057	RENAL DIALYSIS			
058	ASC (NON-DISTINCT PART)			
	OUTPAT SERVICE COST CNTRS			
060	CLINIC			
061	EMERGENCY	104,521		104,521
062	OBSERVATION BEDS (NON-DIS			
063	OTHER OUTPATIENT SERVICE			
063 50	RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
064	HOME PROGRAM DIALYSIS			
065	AMBULANCE SERVICES			
066	DURABLE MEDICAL EQUIP-REN			
067	DURABLE MEDICAL EQUIP-SOL			
070	I&R SERVICES-NOT APPRVD P			
071	HOME HEALTH AGENCY			
	SPEC PURPOSE COST CENTERS			
092	AMBULATORY SURGICAL CENTE			
093	HOSPICE			
095	SUBTOTALS	719,663		719,663
	NONREIMBURS COST CENTERS			
096	GIFT, FLOWER, COFFEE SHOP	4,989		4,989
097	RESEARCH			
098	PHYSICIANS' PRIVATE OFFIC	10,901		10,901
099	NONPAID WORKERS			
100	OTHER NONREIMBURSABLE COS	2,312		2,312
100 01	TOBACCO/CHILD GRANT			
100 02	OUTPATIENT CLINICS	104,399		104,399
100 03	OTHER NONREIMBURSABLE COS	1,504		1,504
100 04	SPN	203,392		203,392
101	CROSS FOOT ADJUSTMENTS			
102	NEGATIVE COST CENTER			
103	TOTAL	1,047,160		1,047,160

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO:
I 15-1303
I

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

I PREPARED 11/24/2010
I WORKSHEET B-1

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-MVBLE E	FITS
	(SQUARE FEET	(DOLLAR VALUE	(SQUARE FEET	(DOLLAR VALUE	(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			69,965			
004 NEW CAP REL COSTS-MVB				69,965		
01 NEW CAP REL COSTS-MVB						
005 EMPLOYEE BENEFITS						6,708,076
006 ADMINISTRATIVE & GENE			6,181	6,181		1,162,685
007 MAINTENANCE & REPAIRS						
008 OPERATION OF PLANT			6,387	6,387		146,207
009 LAUNDRY & LINEN SERVI			76	76		
010 HOUSEKEEPING			1,436	1,436		251,947
011 DIETARY			708	708		32,166
012 CAFETERIA			1,459	1,459		80,895
013 MAINTENANCE OF PERSON						
014 NURSING ADMINISTRATIO			166	166		174,755
015 CENTRAL SERVICES & SU			1,164	1,164		65,015
016 PHARMACY			655	655		161,660
017 MEDICAL RECORDS & LIB			5,541	5,541		818,266
018 SOCIAL SERVICE						
025 INPAT ROUTINE SRVC CN						
026 ADULTS & PEDIATRICS			6,564	6,564		929,786
031 INTENSIVE CARE UNIT						
033 SUBPROVIDER						
034 NURSERY						
035 SKILLED NURSING FACIL						
035 NURSING FACILITY						
01 ICF/MR						
036 OTHER LONG TERM CARE						
037 ANCILLARY SRVC COST C						
038 OPERATING ROOM			5,216	5,216		358,327
039 RECOVERY ROOM						
040 DELIVERY ROOM & LABOR						
041 ANESTHESIOLOGY						
042 RADIOLOGY-DIAGNOSTIC			4,227	4,227		861,798
043 RADIOLOGY-THERAPEUTIC						
044 RADIOISOTOPE						
045 LABORATORY			1,564	1,564		584,984
046 PBP CLINICAL LAB SERV						
047 WHOLE BLOOD & PACKED						
048 BLOOD STORING, PROCES						
049 INTRAVENOUS THERAPY						
050 RESPIRATORY THERAPY						
051 PHYSICAL THERAPY			1,692	1,692		
052 OCCUPATIONAL THERAPY						
053 SPEECH PATHOLOGY						
054 ELECTROCARDIOLOGY			199	199		10,205
055 ELECTROENCEPHALOGRAPH						
055 MEDICAL SUPPLIES CHAR						
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						
062 EMERGENCY			4,222	4,222		933,078
062 OBSERVATION BEDS (NON						
063 OTHER OUTPATIENT SERV						
50 RURAL HEALTH CLINIC						
064 OTHER REIMBURS COST C						
065 HOME PROGRAM DIALYSIS						
066 AMBULANCE SERVICES						
067 DURABLE MEDICAL EQUIP						
070 DURABLE MEDICAL EQUIP						
071 I&R SERVICES-NOT APPR						
092 HOME HEALTH AGENCY						
093 SPEC PURPOSE COST CEN						
095 AMBULATORY SURGICAL C						
HOSPICE						
SUBTOTALS			47,457	47,457		6,571,774
NONREIMBURS COST CENT						
096 GIFT, FLOWER, COFFEE			362	362		
097 RESEARCH						
098 PHYSICIANS' PRIVATE O			791	791		
099 NONPAID WORKERS						
100 OTHER NONREIMBURSABLE						128,241
01 TOBACCO/CHILD GRANT						
02 OUTPATIENT CLINICS			7,440	7,440		8,061
03 OTHER NONREIMBURSABLE						
04 SPN			13,915	13,915		
101 CROSS FOOT ADJUSTMENT						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO:
I 15-1303
I

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

I PREPARED 11/24/2010
I WORKSHEET B-1
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-MVBLE E	FITS
	(SQUARE FEET	(DOLLAR)VALUE	(SQUARE) FEET	(DOLLAR)VALUE	(SQUARE) FEET	(GROSS)ALARIES
	1	2	3	4	4.01	5
NONREIMBURS COST CENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED (WRKSHT B, PART I)			814,885			2,368,567
104 UNIT COST MULTIPLIER (WRKSHT B, PT I)			11.647038			.353092
105 COST TO BE ALLOCATED (WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER (WRKSHT B, PT II)						
107 COST TO BE ALLOCATED (WRKSHT B, PART III)						1,947
108 UNIT COST MULTIPLIER (WRKSHT B, PT III)						.000290

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	RECONCILIATION	ADMINISTRATIVE & GENERAL		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	(ITEMIZED BILL(S))	(HOURS OF SERVICE)	(MEALS SERVED)	(S)
	6a.00	6	7	8	9	10	11	
GENERAL SERVICE COST								
001 OLD CAP REL COSTS-BLD								
002 OLD CAP REL COSTS-MVB								
003 NEW CAP REL COSTS-BLD								
004 NEW CAP REL COSTS-MVB								
004 01 NEW CAP REL COSTS-MVB								
005 EMPLOYEE BENEFITS								
006 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	-3,387,103	14,324,499						
007								
008 OPERATION OF PLANT		943,650		57,397				
009 LAUNDRY & LINEN SERVICE		101,626		76	100,741			
010 HOUSEKEEPING		524,848		1,436	26,668	4,578		
011 DIETARY		26,088		708		168		100
012 CAFETERIA		178,484		1,459	2,934			
013 MAINTENANCE OF PERSONNEL								
014 NURSING ADMINISTRATIVE		243,109		166				
015 CENTRAL SERVICES & SUPPLIES		106,186		1,164				
016 PHARMACY		767,601		655		30		
017 MEDICAL RECORDS & LIBRARY		1,586,061		5,541		40		
018 SOCIAL SERVICE								
025 INPATIENT ROUTINE SERVICE CENTER ADULTS & PEDIATRICS		1,448,080		6,564	11,851	784		100
026 INTENSIVE CARE UNIT								
031 SUBPROVIDER								
033 NURSERY								
034 SKILLED NURSING FACILITY								
035 01 ICF/MR								
036 OTHER LONG TERM CARE								
037 ANCILLARY SERVICE COST CENTER OPERATING ROOM		892,489		5,216	28,800	480		
038 RECOVERY ROOM								
039 DELIVERY ROOM & LABOR								
040 ANESTHESIOLOGY								
041 RADIOLOGY-DIAGNOSTIC		2,459,423		4,227	8,965	304		
042 RADIOLOGY-THERAPEUTIC								
043 RADIOISOTOPE								
044 LABORATORY		1,483,947		1,564	1,276	192		
045 PBP CLINICAL LAB SERVICE								
046 WHOLE BLOOD & PACKED								
047 BLOOD STORING, PROCESSING								
048 INTRAVENOUS THERAPY								
049 RESPIRATORY THERAPY		17,416						
050 PHYSICAL THERAPY		184,994		1,692	5,262	60		
051 OCCUPATIONAL THERAPY		57,224						
052 SPEECH PATHOLOGY		9,914						
053 ELECTROCARDIOLOGY		16,444		199				
054 ELECTROENCEPHALOGRAPHY								
055 MEDICAL SUPPLIES CHARACTERIZED		349,594						
055 30 IMPL. DEV. CHARGED TO PATIENT		180,118						
056 DRUGS CHARGED TO PATIENT								
057 RENAL DIALYSIS								
058 ASC (NON-DISTINCT PARADISE) OUTPATIENT SERVICE COST CENTER CLINIC								
060 EMERGENCY		2,018,327		4,222	12,367	560		
062 OBSERVATION BEDS (NON-REIMBURSABLE)								
063 OTHER OUTPATIENT SERVICE								
063 50 RURAL HEALTH CLINIC								
064 OTHER REIMBURSABLE COST CENTER HOME PROGRAM DIALYSIS								
065 AMBULANCE SERVICES								
066 DURABLE MEDICAL EQUIPMENT								
067 DURABLE MEDICAL EQUIPMENT								
070 I&R SERVICES-NOT APPROPRIATE								
071 HOME HEALTH AGENCY								
092 SPEC PURPOSE COST CENTER AMBULATORY SURGICAL CLINIC								
093 HOSPICE								
095 SUBTOTALS	-3,387,103	13,595,623		34,889	98,123	2,618		100
096 NONREIMBURSABLE COST CENTER GIFT, FLOWER, COFFEE		4,216		362				
097 RESEARCH								
098 PHYSICIANS' PRIVATE OPPORTUNITIES		9,213		791				
099 NONPAID WORKERS								
100 OTHER NONREIMBURSABLE		186,323				80		
100 01 TOBACCO/CHILD GRANT								
100 02 OUTPATIENT CLINICS		99,637		7,440	2,618	200		
100 03 OTHER NONREIMBURSABLE		267,418						
100 04 SPN		162,069		13,915		1,680		
101 CROSS FOOT ADJUSTMENT								

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1303 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)	(ITEMIZED BILL)S	(HOURS OF SERVICE)	(MEALS SERVED)	
NONREIMBURS COST CENT	6a.00	6	7	8	9	10	11	
102 NEGATIVE COST CENTER								
103 COST TO BE ALLOCATED (WRKSHT B, PART I)		3,387,103		1,166,781	127,201	711,814	72,771	
104 UNIT COST MULTIPLIER (WRKSHT B, PT I)		.236455		20.328258	1.262654	155.485802	727.710000	
105 COST TO BE ALLOCATED (WRKSHT B, PART II)								
106 UNIT COST MULTIPLIER (WRKSHT B, PT II)								
107 COST TO BE ALLOCATED (WRKSHT B, PART III)		80,548		118,717	1,613	25,404	12,791	
108 UNIT COST MULTIPLIER (WRKSHT B, PT III)		.005623		2.068349	.016011	5.549148	127.910000	

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	CAFETERIA (HOURS)	MAINTENANCE PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT)SING HRS	CENTRAL SERVICES & SUPPLY NR(COSTED)EQUIS.	SERVI PHARMACY R(COSTED)EQUIS.	MEDICAL RECORDS & LIBRARY R(GROSS CHARGES)	SOCIAL SERVICE (TIME)SPENT
GENERAL SERVICE COST	12	13	14	15	16	17	18
001 OLD CAP REL COSTS-BLD							
002 OLD CAP REL COSTS-MVB							
003 NEW CAP REL COSTS-BLD							
004 NEW CAP REL COSTS-MVB							
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	251,321						
013 MAINTENANCE OF PERSON							
014 NURSING ADMINISTRATION	4,172		116				
015 CENTRAL SERVICES & SU	4,470			350,793			
016 PHARMACY	4,891			172	100		
017 MEDICAL RECORDS & LIB	37,529			387		42,555,679	
018 SOCIAL SERVICE							
025 INPAT ROUTINE SRVC CN							
026 ADULTS & PEDIATRICS	42,294		58	33,250		1,524,779	
026 INTENSIVE CARE UNIT							
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	16,648		14	29,217		4,284,377	
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	35,433		15	28,950		13,033,405	
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY	31,463		12	13,869		9,707,823	
045 PBP CLINICAL LAB SERV							
046 WHOLE BLOOD & PACKED							
047 BLOOD STORING, PROCES							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY				5,309		190,198	
050 PHYSICAL THERAPY				8,492		1,179,989	
051 OCCUPATIONAL THERAPY						333,210	
052 SPEECH PATHOLOGY						11,030	
053 ELECTROCARDIOLOGY						362,034	
054 ELECTROENCEPHALOGRAPH							
055 MEDICAL SUPPLIES CHAR				167,816		1,378,449	
055 30 IMPL. DEV. CHARGED TO						388,469	
056 DRUGS CHARGED TO PATI					100	2,683,972	
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PAR							
060 OUTPAT SERVICE COST C							
061 CLINIC							
061 EMERGENCY	37,368		17	61,859		7,477,944	
062 OBSERVATION BEDS (NON							
063 OTHER OUTPATIENT SERV							
063 50 RURAL HEALTH CLINIC							
064 OTHER REIMBURS COST C							
064 HOME PROGRAM DIALYSIS							
065 AMBULANCE SERVICES							
066 DURABLE MEDICAL EQUIP							
067 DURABLE MEDICAL EQUIP							
070 I&R SERVICES-NOT APPR							
071 HOME HEALTH AGENCY							
092 SPEC PURPOSE COST CEN							
093 AMBULATORY SURGICAL C							
093 HOSPICE							
095 SUBTOTALS	214,268		116	349,321	100	42,555,679	
096 NONREIMBURS COST CENT							
096 GIFT, FLOWER, COFFEE							
097 RESEARCH							
098 PHYSICIANS' PRIVATE O							
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE	8,799			906			
100 01 TOBACCO/CHILD GRANT							
100 02 OUTPATIENT CLINICS	694			566			
100 03 OTHER NONREIMBURSABLE							
100 04 SPN	27,560						
101 CROSS FOOT ADJUSTMENT							

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1303 I FROM 7/ 1/2009 I WORKSHEET B-1
 I I TO 6/30/2010 I

COST CENTER DESCRIPTION	CAFETERIA (HOURS)	MAINTENANCE O F PERSONNEL (NUMBER) HOUSED	NURSING ADMIN ISTRATION (DIRECT) SING HRS	CENTRAL SERVI CES & SUPPLY NR(COSTED) EQUIS.	PHARMACY R(COSTED) EQUIS.	MEDICAL RECOR DS & LIBRARY R(GROSS CHARGES))	SOCIAL SERVIC E (TIME) SPENT
	12	13	14	15	16	17	18
NONREIMBURS COST CENT							
NEGATIVE COST CENTER							
102 COST TO BE ALLOCATED (WRKSHT B, PART I)	254,051		308,184	159,475	972,106	2,118,064	
103 UNIT COST MULTIPLIER (WRKSHT B, PT I)	1.010863		2,656.758621	.454613	9,721.060000	.049772	
104 COST TO BE ALLOCATED (WRKSHT B, PART II)							
105 UNIT COST MULTIPLIER (WRKSHT B, PT II)							
106 COST TO BE ALLOCATED (WRKSHT B, PART III)	21,085		4,044	17,275	15,705	90,009	
107 UNIT COST MULTIPLIER (WRKSHT B, PT III)	.083897		34.862069	.049246	157.050000	.002115	

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1303 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
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	2,421,408		2,421,408		
26	INTENSIVE CARE UNIT					
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	1,601,099		1,601,099		
38	RECOVERY ROOM					
39	DELIVERY ROOM & LABOR ROO					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	3,922,997		3,922,997		
42	RADIOLOGY-THERAPEUTIC					
43	RADIOISOTOPE					
44	LABORATORY	2,451,260		2,451,260		
45	PBP CLINICAL LAB SERVICES					
46	WHOLE BLOOD & PACKED RED					
47	BLOOD STORING, PROCESSING					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	33,415		33,415		
50	PHYSICAL THERAPY	341,696		341,696		
51	OCCUPATIONAL THERAPY	87,340		87,340		
52	SPEECH PATHOLOGY	12,807		12,807		
53	ELECTROCARDIOLOGY	42,396		42,396		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	577,156		577,156		
55	30 IMPL. DEV. CHARGED TO PAT	242,043		242,043		
56	DRUGS CHARGED TO PATIENTS	1,105,693		1,105,693		
57	RENAL DIALYSIS					
58	ASC (NON-DISTINCT PART)					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	3,167,337		3,167,337		
62	OBSERVATION BEDS (NON-DIS	217,496		217,496		
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC					
	OTHER REIMBURS COST CNTRS					
64	HOME PROGRAM DIALYSIS					
65	AMBULANCE SERVICES					
66	DURABLE MEDICAL EQUIP-REN					
67	DURABLE MEDICAL EQUIP-SOL					
101	SUBTOTAL	16,224,143		16,224,143		
102	LESS OBSERVATION BEDS	217,496		217,496		
103	TOTAL	16,006,647		16,006,647		

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1303 I FROM 7/ 1/2009 I WORKSHEET C
 I I TO 6/30/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	1,390,373		1,390,373			
26	INTENSIVE CARE UNIT						
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	25,120	4,259,258	4,284,378	.373706	.373706	
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	401,460	12,631,945	13,033,405	.300996	.300996	
42	RADIOLOGY-THERAPEUTIC						
43	RADIOISOTOPE						
44	LABORATORY	485,502	9,222,321	9,707,823	.252504	.252504	
45	PBP CLINICAL LAB SERVICES						
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	188,336	1,862	190,198	.175685	.175685	
50	PHYSICAL THERAPY	266,886	913,102	1,179,988	.289576	.289576	
51	OCCUPATIONAL THERAPY	184,949	148,261	333,210	.262117	.262117	
52	SPEECH PATHOLOGY	4,459	6,571	11,030	1.161106	1.161106	
53	ELECTROCARDIOLOGY	48,525	313,509	362,034	.117105	.117105	
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	324,441	1,054,008	1,378,449	.418700	.418700	
55	30 IMPL. DEV. CHARGED TO PAT		388,469	388,469	.623069	.623069	
56	DRUGS CHARGED TO PATIENTS	935,711	1,748,262	2,683,973	.411961	.411961	
57	RENAL DIALYSIS						
58	ASC (NON-DISTINCT PART)						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	521,656	6,956,287	7,477,943	.423557	.423557	
62	OBSERVATION BEDS (NON-DIS		134,407	134,407	1.618190	1.618190	
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC						
	OTHER REIMBURS COST CNTRS						
64	HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	4,777,418	37,778,262	42,555,680			
102	LESS OBSERVATION BEDS						
103	TOTAL	4,777,418	37,778,262	42,555,680			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
I 15-1303 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	2,421,408		2,421,408		
26	INTENSIVE CARE UNIT					
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	1,601,099		1,601,099		
38	RECOVERY ROOM					
39	DELIVERY ROOM & LABOR ROO					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	3,922,997		3,922,997		
42	RADIOLOGY-THERAPEUTIC					
43	RADIOISOTOPE					
44	LABORATORY	2,451,260		2,451,260		
45	PBP CLINICAL LAB SERVICES					
46	WHOLE BLOOD & PACKED RED					
47	BLOOD STORING, PROCESSING					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	33,415		33,415		
50	PHYSICAL THERAPY	341,696		341,696		
51	OCCUPATIONAL THERAPY	87,340		87,340		
52	SPEECH PATHOLOGY	12,807		12,807		
53	ELECTROCARDIOLOGY	42,396		42,396		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	577,156		577,156		
55	30 IMPL. DEV. CHARGED TO PAT	242,043		242,043		
56	DRUGS CHARGED TO PATIENTS	1,105,693		1,105,693		
57	RENAL DIALYSIS					
58	ASC (NON-DISTINCT PART)					
60	OUTPAT SERVICE COST CNTRS CLINIC					
61	EMERGENCY	3,167,337		3,167,337		
62	OBSERVATION BEDS (NON-DIS	217,496		217,496		
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC					
64	OTHER REIMBURS COST CNTRS					
64	HOME PROGRAM DIALYSIS					
65	AMBULANCE SERVICES					
66	DURABLE MEDICAL EQUIP-REN					
67	DURABLE MEDICAL EQUIP-SOL					
101	SUBTOTAL	16,224,143		16,224,143		
102	LESS OBSERVATION BEDS	217,496		217,496		
103	TOTAL	16,006,647		16,006,647		

COMPUTATION OF RATIO OF COSTS TO CHARGES
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	1,390,373		1,390,373			
26	INTENSIVE CARE UNIT						
31	SUBPROVIDER						
33	NURSERY						
34	SKILLED NURSING FACILITY						
35	NURSING FACILITY						
35	01 ICF/MR						
36	OTHER LONG TERM CARE						
37	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	25,120	4,259,258	4,284,378	.373706	.373706	
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	401,460	12,631,945	13,033,405	.300996	.300996	
42	RADIOLOGY-THERAPEUTIC						
43	RADIOISOTOPE						
44	LABORATORY	485,502	9,222,321	9,707,823	.252504	.252504	
45	PBP CLINICAL LAB SERVICES						
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	188,336	1,862	190,198	.175685	.175685	
50	PHYSICAL THERAPY	266,886	913,102	1,179,988	.289576	.289576	
51	OCCUPATIONAL THERAPY	184,949	148,261	333,210	.262117	.262117	
52	SPEECH PATHOLOGY	4,459	6,571	11,030	1.161106	1.161106	
53	ELECTROCARDIOLOGY	48,525	313,509	362,034	.117105	.117105	
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	324,441	1,054,008	1,378,449	.418700	.418700	
55	30 IMPL. DEV. CHARGED TO PAT		388,469	388,469	.623069	.623069	
56	DRUGS CHARGED TO PATIENTS	935,711	1,748,262	2,683,973	.411961	.411961	
57	RENAL DIALYSIS						
58	ASC (NON-DISTINCT PART)						
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
61	EMERGENCY	521,656	6,956,287	7,477,943	.423557	.423557	
62	OBSERVATION BEDS (NON-DIS		134,407	134,407	1.618190	1.618190	
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC						
64	OTHER REIMBURS COST CNTRS						
64	HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	4,777,418	37,778,262	42,555,680			
102	LESS OBSERVATION BEDS						
103	TOTAL	4,777,418	37,778,262	42,555,680			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B, PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
38	OPERATING ROOM	1,601,099	149,518	1,451,581			1,601,099
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO						
41	ANESTHESIOLOGY						
42	RADIOLOGY-DIAGNOSTIC	3,922,997	168,454	3,754,543			3,922,997
43	RADIOLOGY-THERAPEUTIC						
44	RADIOISOTOPE						
45	LABORATORY	2,451,260	77,161	2,374,099			2,451,260
46	PBP CLINICAL LAB SERVICES						
47	WHOLE BLOOD & PACKED RED						
48	BLOOD STORING, PROCESSING						
49	INTRAVENOUS THERAPY						
50	RESPIRATORY THERAPY	33,415	761	32,654			33,415
51	PHYSICAL THERAPY	341,696	30,329	311,367			341,696
52	OCCUPATIONAL THERAPY	87,340	1,027	86,313			87,340
53	SPEECH PATHOLOGY	12,807	79	12,728			12,807
54	ELECTROCARDIOLOGY	42,396	3,909	38,487			42,396
55	ELECTROENCEPHALOGRAPHY						
56	MEDICAL SUPPLIES CHARGED	577,156	13,146	564,010			577,156
57	30 IMPL. DEV. CHARGED TO PAT	242,043	1,835	240,208			242,043
58	DRUGS CHARGED TO PATIENTS	1,105,693	21,382	1,084,311			1,105,693
59	RENAL DIALYSIS						
60	ASC (NON-DISTINCT PART)						
61	OUTPAT SERVICE COST CNTRS						
62	CLINIC						
63	EMERGENCY	3,167,337	104,521	3,062,816			3,167,337
64	OBSERVATION BEDS (NON-DIS	217,496		217,496			217,496
65	OTHER OUTPATIENT SERVICE						
66	50 RURAL HEALTH CLINIC						
67	OTHER REIMBURS COST CNTRS						
68	HOME PROGRAM DIALYSIS						
69	AMBULANCE SERVICES						
70	DURABLE MEDICAL EQUIP-REN						
71	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	13,802,735	572,122	13,230,613			13,802,735
102	LESS OBSERVATION BEDS	217,496		217,496			217,496
103	TOTAL	13,585,239	572,122	13,013,117			13,585,239

WKST A	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
LINE NO.		7	8	9
37	ANCILLARY SRVC COST CNTRS			
	OPERATING ROOM	4,284,378	.373706	.373706
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROO			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	13,033,405	.300996	.300996
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	9,707,823	.252504	.252504
45	PBP CLINICAL LAB SERVICES			
46	WHOLE BLOOD & PACKED RED			
47	BLOOD STORING, PROCESSING			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	190,198	.175685	.175685
50	PHYSICAL THERAPY	1,179,988	.289576	.289576
51	OCCUPATIONAL THERAPY	333,210	.262117	.262117
52	SPEECH PATHOLOGY	11,030	1.161106	1.161106
53	ELECTROCARDIOLOGY	362,034	.117105	.117105
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	1,378,449	.418700	.418700
55	30 IMPL. DEV. CHARGED TO PAT	388,469	.623069	.623069
56	DRUGS CHARGED TO PATIENTS	2,683,973	.411961	.411961
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART)			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	7,477,943	.423557	.423557
62	OBSERVATION BEDS (NON-DIS	134,407	1.618190	1.618190
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-REN			
67	DURABLE MEDICAL EQUIP-SOL			
101	SUBTOTAL	41,165,307		
102	LESS OBSERVATION BEDS	134,407		
103	TOTAL	41,030,900		

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						
38	OPERATING ROOM	1,601,099	149,518	1,451,581			1,601,099
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO						
41	ANESTHESIOLOGY						
42	RADIOLOGY-DIAGNOSTIC	3,922,997	168,454	3,754,543			3,922,997
43	RADIOLOGY-THERAPEUTIC						
44	RADIOISOTOPE						
45	LABORATORY	2,451,260	77,161	2,374,099			2,451,260
46	PBP CLINICAL LAB SERVICES						
47	WHOLE BLOOD & PACKED RED						
48	BLOOD STORING, PROCESSING						
49	INTRAVENOUS THERAPY						
50	RESPIRATORY THERAPY	33,415	761	32,654			33,415
51	PHYSICAL THERAPY	341,696	30,329	311,367			341,696
52	OCCUPATIONAL THERAPY	87,340	1,027	86,313			87,340
53	SPEECH PATHOLOGY	12,807	79	12,728			12,807
54	ELECTROCARDIOLOGY	42,396	3,909	38,487			42,396
55	ELECTROENCEPHALOGRAPHY						
56	MEDICAL SUPPLIES CHARGED	577,156	13,146	564,010			577,156
57	30 IMPL. DEV. CHARGED TO PAT	242,043	1,835	240,208			242,043
58	DRUGS CHARGED TO PATIENTS	1,105,693	21,382	1,084,311			1,105,693
59	RENAL DIALYSIS						
60	ASC (NON-DISTINCT PART)						
61	OUTPAT SERVICE COST CNTRS						
62	CLINIC						
63	EMERGENCY	3,167,337	104,521	3,062,816			3,167,337
64	OBSERVATION BEDS (NON-DIS	217,496		217,496			217,496
65	OTHER OUTPATIENT SERVICE						
66	50 RURAL HEALTH CLINIC						
67	OTHER REIMBURS COST CNTRS						
68	HOME PROGRAM DIALYSIS						
69	AMBULANCE SERVICES						
70	DURABLE MEDICAL EQUIP-REN						
71	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	13,802,735	572,122	13,230,613			13,802,735
102	LESS OBSERVATION BEDS	217,496		217,496			217,496
103	TOTAL	13,585,239	572,122	13,013,117			13,585,239

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			
	OPERATING ROOM	4,284,378	.373706	.373706
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROO			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	13,033,405	.300996	.300996
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	9,707,823	.252504	.252504
45	PBP CLINICAL LAB SERVICES			
46	WHOLE BLOOD & PACKED RED			
47	BLOOD STORING, PROCESSING			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	190,198	.175685	.175685
50	PHYSICAL THERAPY	1,179,988	.289576	.289576
51	OCCUPATIONAL THERAPY	333,210	.262117	.262117
52	SPEECH PATHOLOGY	11,030	1.161106	1.161106
53	ELECTROCARDIOLOGY	362,034	.117105	.117105
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	1,378,449	.418700	.418700
55	30 IMPL. DEV. CHARGED TO PAT	388,469	.623069	.623069
56	DRUGS CHARGED TO PATIENTS	2,683,973	.411961	.411961
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART)			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	7,477,943	.423557	.423557
62	OBSERVATION BEDS (NON-DIS	134,407	1.618190	1.618190
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-REN			
67	DURABLE MEDICAL EQUIP-SOL			
101	SUBTOTAL	41,165,307		
102	LESS OBSERVATION BEDS	134,407		
103	TOTAL	41,030,900		

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	.373706		.373706		
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC	.300996		.300996		
42 RADIOLOGY-THERAPEUTIC					
43 RADIOISOTOPE					
44 LABORATORY	.252504		.252504		
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	.175685		.175685		
50 PHYSICAL THERAPY	.289576		.289576		
51 OCCUPATIONAL THERAPY	.262117		.262117		
52 SPEECH PATHOLOGY	1.161106		1.161106		
53 ELECTROCARDIOLOGY	.117105		.117105		
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.418700		.418700		
55 30 IMPL. DEV. CHARGED TO PATIENT	.623069		.623069		
56 DRUGS CHARGED TO PATIENTS	.411961		.411961		
57 RENAL DIALYSIS					
58 ASC (NON-DISTINCT PART)					
60 OUTPAT SERVICE COST CNTRS					
61 CLINIC					
61 EMERGENCY	.423557		.423557		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.618190		1.618190		
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
64 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

	Other Outpatient Diagnostic	All other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other outpatient Diagnostic
Cost Center Description	4	5	6	7	8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		1,690,776			
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC		2,815,308			
42 RADIOLOGY-THERAPEUTIC					
43 RADIOISOTOPE					
44 LABORATORY		2,892,267			
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		1,862			
50 PHYSICAL THERAPY		222,318			
51 OCCUPATIONAL THERAPY		44,306			
52 SPEECH PATHOLOGY		3,647			
53 ELECTROCARDIOLOGY		249,348			
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		292,768			
55 30 IMPL. DEV. CHARGED TO PATIENT		257,058			
56 DRUGS CHARGED TO PATIENTS		873,806			
57 RENAL DIALYSIS					
58 ASC (NON-DISTINCT PART)					
60 OUTPAT SERVICE COST CNTRS					
61 CLINIC					
61 EMERGENCY		1,692,539			
62 OBSERVATION BEDS (NON-DISTINCT PART)		39,047			
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
64 OTHER REIMBURS COST CNTRS					
64 HOME PROGRAM DIALYSIS					
65 AMBULANCE SERVICES					
66 DURABLE MEDICAL EQUIP-RENTED					
67 DURABLE MEDICAL EQUIP-SOLD					
101 SUBTOTAL		11,075,050			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		11,075,050			

(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	631,853		
38 RECOVERY ROOM			
39 DELIVERY ROOM & LABOR ROOM			
40 ANESTHESIOLOGY			
41 RADIOLOGY-DIAGNOSTIC	847,396		
42 RADIOLOGY-THERAPEUTIC			
43 RADIOISOTOPE			
44 LABORATORY	730,309		
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	327		
50 PHYSICAL THERAPY	64,378		
51 OCCUPATIONAL THERAPY	11,613		
52 SPEECH PATHOLOGY	4,235		
53 ELECTROCARDIOLOGY	29,200		
54 ELECTROENCEPHALOGRAPHY			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	122,582		
55 30 IMPL. DEV. CHARGED TO PATIENT	160,165		
56 DRUGS CHARGED TO PATIENTS	359,974		
57 RENAL DIALYSIS			
58 ASC (NON-DISTINCT PART)			
OUTPAT SERVICE COST CNTRS			
60 CLINIC			
61 EMERGENCY	716,887		
62 OBSERVATION BEDS (NON-DISTINCT PART)	63,185		
63 OTHER OUTPATIENT SERVICE COST CENTER			
63 50 RURAL HEALTH CLINIC			
OTHER REIMBURS COST CNTRS			
64 HOME PROGRAM DIALYSIS			
65 AMBULANCE SERVICES			
66 DURABLE MEDICAL EQUIP-RENTED			
67 DURABLE MEDICAL EQUIP-SOLD			
101 SUBTOTAL	3,742,104		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104 NET CHARGES	3,742,104		

(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	.411961
2	PROGRAM VACCINE CHARGES		398
3	PROGRAM COSTS		164

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)	1,825
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,164
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,164
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	339
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)	273
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	25
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)	24
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	647
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	339
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)	273
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	2,421,408
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	3,669
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	3,522
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	839,119
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,582,289

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,270,107
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,270,107
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.245792
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,091.16
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	1,582,289

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	1,359.36
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	879,506
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	879,506

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

372,237
 1,251,743

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)	460,823
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	371,105
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	831,928
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	160
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,359.35
85	OBSERVATION BED COST	217,496

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)	1,825
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,164
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,164
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)	612
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)	49
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	103
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)	1,270,107
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,270,107
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,091.16
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 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					244,466
49 TOTAL PROGRAM INPATIENT COSTS					244,466

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

244,466

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)

36

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

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	160
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				

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1303 I FROM 7/ 1/2009 I WORKSHEET D-4
 I COMPONENT NO: I TO 6/30/2010 I
 I 15-1303 I I

TITLE XVIII, PART A

HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		530,028	
26	INTENSIVE CARE UNIT			
31	SUBPROVIDER			
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.373706	8,055	3,010
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.300996	145,265	43,724
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	.252504	229,913	58,054
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	.175685	83,877	14,736
50	PHYSICAL THERAPY	.289576	60,322	17,468
51	OCCUPATIONAL THERAPY	.262117	28,455	7,459
52	SPEECH PATHOLOGY	1.161106	510	592
53	ELECTROCARDIOLOGY	.117105	45,045	5,275
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.418700	153,731	64,367
55	30 IMPL. DEV. CHARGED TO PATIENT	.623069		
56	DRUGS CHARGED TO PATIENTS	.411961	382,445	157,552
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART) OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.423557		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.618190		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD			
101	TOTAL		1,137,618	372,237
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,137,618	

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
INPAT ROUTINE SRVC CNTRS			
25 ADULTS & PEDIATRICS			
26 INTENSIVE CARE UNIT			
31 SUBPROVIDER			
ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM	.373706	8,411	3,143
38 RECOVERY ROOM			
39 DELIVERY ROOM & LABOR ROOM			
40 ANESTHESIOLOGY			
41 RADIOLOGY-DIAGNOSTIC	.300996	23,565	7,093
42 RADIOLOGY-THERAPEUTIC			
43 RADIOISOTOPE			
44 LABORATORY	.252504	55,866	14,106
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	.175685	57,443	10,092
50 PHYSICAL THERAPY	.289576	186,500	54,006
51 OCCUPATIONAL THERAPY	.262117	138,678	36,350
52 SPEECH PATHOLOGY	1.161106	3,649	4,237
53 ELECTROCARDIOLOGY	.117105	2,316	271
54 ELECTROENCEPHALOGRAPHY			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.418700	104,303	43,672
55 30 IMPL. DEV. CHARGED TO PATIENT	.623069		
56 DRUGS CHARGED TO PATIENTS	.411961	261,793	107,849
57 RENAL DIALYSIS			
58 ASC (NON-DISTINCT PART)			
OUTPAT SERVICE COST CNTRS			
60 CLINIC			
61 EMERGENCY	.423557		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.618190		
63 OTHER OUTPATIENT SERVICE COST CENTER			
63 50 RURAL HEALTH CLINIC			
OTHER REIMBURS COST CNTRS			
64 HOME PROGRAM DIALYSIS			
65 AMBULANCE SERVICES			
66 DURABLE MEDICAL EQUIP-RENTED			
67 DURABLE MEDICAL EQUIP-SOLD			
101 TOTAL		842,524	280,819
102 LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103 NET CHARGES		842,524	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1303 I FROM 7/ 1/2009 I WORKSHEET D-4
 I COMPONENT NO: I TO 6/30/2010 I
 I 15-1303 I I

TITLE XIX

HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		34,523	
26	INTENSIVE CARE UNIT			
31	SUBPROVIDER			
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.373706	4,839	1,808
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.300996	11,796	3,551
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	.252504	11,905	3,006
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	.175685	6,768	1,189
50	PHYSICAL THERAPY	.289576	1,172	339
51	OCCUPATIONAL THERAPY	.262117	669	175
52	SPEECH PATHOLOGY	1.161106		
53	ELECTROCARDIOLOGY	.117105	1,164	136
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.418700		
55	30 IMPL. DEV. CHARGED TO PATIENT	.623069		
56	DRUGS CHARGED TO PATIENTS	.411961	32,312	13,311
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART) OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.423557	521,656	220,951
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.618190		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD			
101	TOTAL		592,281	244,466
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		592,281	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/24/2010
I	15-1303	I	FROM 7/ 1/2009	I	WORKSHEET E
I	COMPONENT NO:	I	TO 6/30/2010	I	PART B
I	15-1303	I		I	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,742,268
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)	3,742,268
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	3,779,691
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	CAH DEDUCTIBLES	26,538
18.01	CAH ACTUAL BILLED COINSURANCE	1,636,756
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	2,116,397
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	2,116,397
24	PRIMARY PAYER PAYMENTS	795
25	SUBTOTAL	2,115,602
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	508,103
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	508,103
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	454,722
28	SUBTOTAL	2,623,705
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	2,623,705
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	2,596,792
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	26,913
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

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1303 I FROM 7/ 1/2009 I WORKSHEET E-1
 I COMPONENT NO: I TO 6/30/2010 I
 I 15-1303 I I

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		1,036,165		1,997,206
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	78,028	5/20/2010	710,559
ADJUSTMENTS TO PROVIDER .02	6/30/2010	19,599		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50			6/30/2010	110,973
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		97,627		599,586
4 TOTAL INTERIM PAYMENTS		1,133,792		2,596,792
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)				26,913
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02		10,593		
7 TOTAL MEDICARE PROGRAM LIABILITY		1,123,199		2,623,705

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1303 I FROM 7/ 1/2009 I WORKSHEET E-1
 I COMPONENT NO: I TO 6/30/2010 I
 I 15-2303 I I

TITLE XVIII

SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		932,080		
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	110,298		
ADJUSTMENTS TO PROVIDER .02	6/30/2010	78,987		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		189,285		NONE
4 TOTAL INTERIM PAYMENTS		1,121,365		
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL .99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER .01		15,652		
SETTLEMENT TO PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY		1,105,713		

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 11/24/2010
I	15-1303	I	FROM 7/ 1/2009	I	
I	COMPONENT NO:	I	TO 6/30/2010	I	WORKSHEET E-2
I	15-Z303	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)	840,247	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	283,627	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	612	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	1,123,874	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	1,123,874	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	1,123,874	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS) (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	18,161	
14	80% OF PART B COSTS		
15	SUBTOTAL	1,105,713	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	1,105,713	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	1,121,365	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	-15,652	
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 11/24/2010
I	15-1303	I	FROM 7/ 1/2009	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 6/30/2010	I	PART II
I	15-1303	I		I	

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	1,251,743
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	1,251,743
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	1,264,260
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	1,264,260
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	189,234
21	EXCESS REASONABLE COST	
22	SUBTOTAL	1,075,026
23	COINSURANCE	
24	SUBTOTAL	1,075,026
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	48,173
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	48,173
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	48,173
26	SUBTOTAL	1,123,199
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	1,123,199
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	1,133,792
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	-10,593
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

BALANCE SHEET

		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	2,752,594			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	5,345,441			
5	OTHER RECEIVABLES				
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-3,178,980			
7	INVENTORY	147,041			
8	PREPAID EXPENSES	70,888			
9	OTHER CURRENT ASSETS	74,534	135,685		
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	5,211,518	135,685		
FIXED ASSETS					
12	LAND	127,944			
12.01					
13	LAND IMPROVEMENTS	400,829			
13.01	LESS ACCUMULATED DEPRECIATION	-369,751			
14	BUILDINGS	13,498,332			
14.01	LESS ACCUMULATED DEPRECIATION	-3,990,384			
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT	4,108,719			
16.01	LESS ACCUMULATED DEPRECIATION	-3,490,858			
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	10,284,831			
OTHER ASSETS					
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	1,570,141			
26	TOTAL OTHER ASSETS	1,570,141			
27	TOTAL ASSETS	17,066,490	135,685		

BALANCE SHEET

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	299,790			
29 SALARIES, WAGES & FEES PAYABLE	906,610			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	88,918			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS	276,261			
35 OTHER CURRENT LIABILITIES	887,826			
36 TOTAL CURRENT LIABILITIES	2,459,405			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	10,931,483			
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES	1,146,005			
42 TOTAL LONG-TERM LIABILITIES	12,077,488			
43 TOTAL LIABILITIES	14,536,893			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	2,529,597			
45 SPECIFIC PURPOSE FUND		135,685		
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	2,529,597	135,685		
52 TOTAL LIABILITIES AND FUND BALANCES	17,066,490	135,685		

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4
1 FUND BALANCE AT BEGINNING		2,681,488		76,212
2 OF PERIOD				
3 NET INCOME (LOSS)		-302,357		
4 TOTAL		2,379,131		76,212
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
6 DEFERRED PENSION COSTS	181,540			
7 CONTRIBUTIONS			39,010	
8 GRANT REVENUE - FEDERAL			11,791	
9 GRANT REVENUE - OTHER			182,555	
10 TOTAL ADDITIONS		181,540		233,356
11 SUBTOTAL		2,560,671		309,568
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 NET ASSETS RELEASED FROM			173,883	
14 OTHER UNRESTRICTED ACTIVI	677			
15 TRANSFER TO AFFILIATES	30,397			
16 TRANSFER TO AFFILIATES				
17 TOTAL DEDUCTIONS		31,074		173,883
18 FUND BALANCE AT END OF		2,529,597		135,685
19 PERIOD PER BALANCE SHEET				

	ENDOWMENT FUND 5	6	PLANT FUND 7	8
1 FUND BALANCE AT BEGINNING				
2 OF PERIOD				
3 NET INCOME (LOSS)				
4 TOTAL				
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
6 DEFERRED PENSION COSTS				
7 CONTRIBUTIONS				
8 GRANT REVENUE - FEDERAL				
9 GRANT REVENUE - OTHER				
10 TOTAL ADDITIONS				
11 SUBTOTAL				
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 NET ASSETS RELEASED FROM				
14 OTHER UNRESTRICTED ACTIVI				
15 TRANSFER TO AFFILIATES				
16 TRANSFER TO AFFILIATES				
17 TOTAL DEDUCTIONS				
18 FUND BALANCE AT END OF				
19 PERIOD PER BALANCE SHEET				

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	1,270,107		1,270,107
2 00 SUBPROVIDER			
4 00 SWING BED - SNF	312,909		312,909
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	1,583,016		1,583,016
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	1,583,016		1,583,016
17 00 ANCILLARY SERVICES	4,687,171		4,687,171
18 00 OUTPATIENT SERVICES		38,530,759	38,530,759
18 50 RURAL HEALTH CLINIC			
19 00 HOME HEALTH AGENCY			
20 00 AMBULANCE SERVICES			
22 00 AMBULATORY SURGICAL CENTER (D.P.)			
23 00 HOSPICE			
24 00			
25 00 TOTAL PATIENT REVENUES	6,270,187	38,530,759	44,800,946

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		17,979,752	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		17,979,752	

STATEMENT OF REVENUES AND EXPENSES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/24/2010
I	15-1303	I	FROM 7/ 1/2009	I	WORKSHEET G-3
I		I	TO 6/30/2010	I	

DESCRIPTION		
1	TOTAL PATIENT REVENUES	44,800,946
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	24,193,778
3	NET PATIENT REVENUES	20,607,168
4	LESS: TOTAL OPERATING EXPENSES	17,979,752
5	NET INCOME FROM SERVICE TO PATIENTS	2,627,416
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	
7	INCOME FROM INVESTMENTS	97,500
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	27,788
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	13,682
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	400,472
23	GOVERNMENTAL APPROPRIATIONS	
24	ADMINISTRATIVE WRITE-OFFS	-139,074
24.01	NET ASSETS RELEASED FROM RESTRICT	173,883
24.02	MISC	27,358
24.03	RHC MISC	-186
24.04	UNREALIZED GAIN	83,225
25	TOTAL OTHER INCOME	684,648
26	TOTAL	3,312,064
	OTHER EXPENSES	
27	BAD DEBTS	3,614,365
28	JFC PHYSICIAN REV	56
29		
30	TOTAL OTHER EXPENSES	3,614,421
31	NET INCOME (OR LOSS) FOR THE PERIOD	-302,357