

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	15-1312	I	FROM 1/ 1/2010	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 12/31/2010	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/20/2011 TIME 9:58

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:
WHITE COUNTY MEMORIAL HOSPITAL 15-1312
FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2010 AND ENDING 12/31/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX
	1	2	3	4	
1	HOSPITAL	0	-212,322	-438,094	455,451
3	SWING BED - SNF	0	-106,841	0	0
7	HOSPITAL-BASED HHA	0	1	1	0
100	TOTAL	0	-319,162	-438,093	455,451

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: 720 SOUTH SIXTH STREET P.O. BOX:
 1.01 CITY: MONTICELLO STATE: IN ZIP CODE: 47960- COUNTY: WHITE

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT 0	COMPONENT NAME 1	PROVIDER NO. 2	NPI NUMBER 2.01	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)		
					V 4	XVIII 5	XIX 6
02.00	HOSPITAL	15-1312	2.01	7/ 1/1966	N	O	O
04.00	SWING BED - SNF	15-Z312		2/16/1990	N	O	N
09.00	HOSPITAL-BASED HHA	15-7514		3/ 1/1997	N	O	N

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

18 TYPE OF CONTROL 1 2
9

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
20 SUBPROVIDER

OTHER INFORMATION

- 21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.
- 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. N
- 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
- 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 N Y 15000
- 21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2
- 21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2
- 21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION (OR APPLICABLE EXTENSION) OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105, MIPPA §147, ACA §3121 OR MMEA §108? "Y" FOR YES, AND "N" FOR NO. N
- 21.07 DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER IN COL 1 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 or MMEA §108? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. (SEE INSTRUCTIONS) N N
- 21.08 WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEEDING COST REPORTING PERIOD? ENTER IN COLUMN 2, "Y" FOR YES OR "N" FOR NO. 3 N
- 22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N
- 23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N
- 23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. / / / /
- 23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY) / /
- 24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). / /

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

25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?
 25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.

25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.
 25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N
 25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES OR "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS) N
 25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES OR "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)
 25.07 HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THE COST REPORTING PERIOD? ENTER "Y" FOR YES OR "N" FOR NO IN COLUMN 1.
 25.08 IF LINE 25.07 IS YES, ENTER IN COLUMN 1 THE WEIGHTED NUMBER OF NON-PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. 0.00

IF LINE 25.07 IS YES, USE LINES 25.09 THROUGH 25.59 AS NECESSARY TO IDENTIFY THE PROGRAM NAME IN COLUMN 1, THE PROGRAM CODE IN COLUMN 2, AND THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENTS FTES BY PROGRAM IN COLUMN 3 FOR EACH PRIMARY CARE SPECIALTY PROGRAM IN WHICH RESIDENTS ARE TRAINED. (SEE INSTRUCTIONS)

25.09 0000 0.00
 26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0
 26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /
 26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /
 27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. N / /
 28 IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02
 28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. 1 2 3 4
 ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS) 0 0.0000 0.0000
 28.02 ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY 0.00 0
 A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR) % Y/N
 28.03 STAFFING 0.00%
 28.04 RECRUITMENT 0.00%
 28.05 RETENTION 0.00%
 28.06 TRAINING 0.00%

29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? N
 30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) Y
 30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70 N
 30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS) N
 30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).
 30.04 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II N
 31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
 31.01 IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
 31.02 IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
 31.03 IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
 31.04 IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
 31.05 IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

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

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

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

TITLE XIX INPATIENT SERVICES

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

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

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

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

	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).				0	
59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)		N			
60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)		N			
60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(c)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC).				0	

MULTICAMPUS

61.00 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA? ENTER "Y" FOR YES AND "N" FOR NO.

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

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00

SETTLEMENT DATA

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

MISCELLANEOUS DATA

64.00 DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. Y

COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	I/P DAYS / TITLE XVIII	O/P VISITS / NOT LTCH N/A	TRIPS / TITLE XIX
1 ADULTS & PEDIATRICS	24	8,760	81,840.00	3	4	1,903	497
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)						924	
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	24	8,760	81,840.00			2,827	497
6 INTENSIVE CARE UNIT	1	365	3,168.00			87	5
11 NURSERY							356
12 TOTAL	25	9,125	85,008.00			2,914	858
13 RPCH VISITS							
18 HOME HEALTH AGENCY						3,439	
25 TOTAL	25						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	TITLE XIX OBSERVATION ADMITTED	I/P DAYS / OBSERVATION BEDS NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	/ TRIPS / TOTAL OBSERVATION ADMITTED	DISCHARGES / TOTAL OBSERVATION NOT ADMITTED	-- INTERNS & RES. / TOTAL	-- FTES / LESS I&R REPL NON-PHYS ANES
1 ADULTS & PEDIATRICS	5.01	5.02	6	6.01	6.02	7	8
2 HMO			3,410				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			941				
4 ADULTS & PED-SB NF			130				
5 TOTAL ADULTS AND PEDS			4,481				
6 INTENSIVE CARE UNIT			132				
11 NURSERY			496				
12 TOTAL			5,109				
13 RPCH VISITS							
18 HOME HEALTH AGENCY			7,654				
25 TOTAL							
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	I & R FTES NET	--- FULL TIME EMPLOYEES ON PAYROLL	EQUIV NONPAID WORKERS	TITLE V	DISCHARGES TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2 HMO					600	206	1,169
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		226.39			600	206	1,169
13 RPCH VISITS							
18 HOME HEALTH AGENCY		10.36					
25 TOTAL		236.75					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

HHA 1

	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4
1 HOME HEALTH AIDE HOURS	0	0	0	0
2 UNDUPLICATED CENSUS COUNT		127.00		
	TOTAL			
	5			
1 HOME HEALTH AIDE HOURS	0			
2 UNDUPLICATED CENSUS COUNT				
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)				
ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK				

HHA NO. OF FTE EMPLOYEES (2080 HRS)

	STAFF 1	CONTRACT 2	TOTAL 3
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)			
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			
5 OTHER ADMINISTRATIVE PERSONEL			
6 DIRECTING NURSING SERVICE			
7 NURSING SUPERVISOR			
8 PHYSICAL THERAPY SERVICE			
9 PHYSICAL THERAPY SUPERVISOR			
10 OCCUPATIONAL THERAPY SERVICE			
11 OCCUPATIONAL THERAPY SUPERVISOR			
12 SPEECH PATHOLOGY SERVICE			
13 SPEECH PATHOLOGY SUPERVISOR			
14 MEDICAL SOCIAL SERVICE			
15 MEDICAL SOCIAL SERVICE SUPERVISOR			
16 HOME HEALTH AIDE			
17 HOME HEALTH AIDE SUPERVISOR			
18			
HOME HEALTH AGENCY MSA CODES	1	1.01	
19 HOW MANY MSAs IN COL. 1 OR CBSAs IN COL. 1.01 DID YOU PROVIDER SERVICES TO DURING THE C/R PERIOD?	0	0	
20 LIST THOSE MSA CODE(S) IN COL. 1 & CBSA CODE(S) IN COL. 1.01 SERVICED DURING THIS C/R PERIOD (LINE 20 CONTAINS THE FIRST CODE).			

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

	FULL EPISODES		LUPA EPISODES 3	PEP ONLY EPISODES 4
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2		
21 SKILLED NURSING VISITS	1,218	25	23	14
22 SKILLED NURSING VISIT CHARGES	116,928	2,400	2,208	1,344
23 PHYSICAL THERAPY VISITS	1,314	0	6	16
24 PHYSICAL THERAPY VISIT CHARGES	141,912	0	648	1,728
25 OCCUPATIONAL THERAPY VISITS	20	0	0	0
26 OCCUPATIONAL THERAPY VISIT CHARGES	2,180	0	0	0
27 SPEECH PATHOLOGY VISITS	75	0	0	0
28 SPEECH PATHOLOGY VISIT CHARGES	8,400	0	0	0
29 MEDICAL SOCIAL SERVICE VISITS	0	0	0	0
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0	0
31 HOME HEALTH AIDE VISITS	697	21	1	9
32 HOME HEALTH AIDE VISIT CHARGES	34,801	1,050	50	450
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	3,324	46	30	39
34 OTHER CHARGES	0	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	304,221	3,450	2,906	3,522
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	158	0	11	2
37 TOTAL NUMBER OF OUTLIER EPISODES	0	1	0	0
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	1,242	0	29	9

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

I PROVIDER NO:
I 15-1312
I HHA NO:
I 15-7514
COUNTY:

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

I PREPARED 5/20/2011
I WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

HHA 1

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

	SCIC WITHIN A PEP 5	SCIC ONLY EPISODES 6	TOTAL (COLS. 1-6) 7
21 SKILLED NURSING VISITS	0	0	1,280
22 SKILLED NURSING VISIT CHARGES	0	0	122,880
23 PHYSICAL THERAPY VISITS	0	0	1,336
24 PHYSICAL THERAPY VISIT CHARGES	0	0	144,288
25 OCCUPATIONAL THERAPY VISITS	0	0	20
26 OCCUPATIONAL THERAPY VISIT CHARGES	0	0	2,180
27 SPEECH PATHOLOGY VISITS	0	0	75
28 SPEECH PATHOLOGY VISIT CHARGES	0	0	8,400
29 MEDICAL SOCIAL SERVICE VISITS	0	0	0
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0
31 HOME HEALTH AIDE VISITS	0	0	728
32 HOME HEALTH AIDE VISIT CHARGES	0	0	36,351
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	0	0	3,439
34 OTHER CHARGES	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	0	0	314,099
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	0	0	171
37 TOTAL NUMBER OF OUTLIER EPISODES	0	0	1
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	0	0	1,280

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
 I 15-1312 I FROM 1/ 1/2010 I WORKSHEET A
 I I TO 12/31/2010 I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
1	0100 OLD CAP REL COSTS-BLDG & FIXT		163,157	163,157		163,157
1.01	0101 OLD CAP REL COSTS-BLDG & FIXT-HOSP		3,360,796	3,360,796		3,360,796
1.03	0103 OLD CAP REL COSTS-BLDG & FIXT-TLMAB		948,919	948,919		948,919
5	0500 EMPLOYEE BENEFITS	88,729	1,915,429	2,004,158		2,004,158
6	0600 ADMINISTRATIVE & GENERAL	1,955,777	1,356,876	3,312,653		3,312,653
8	0800 OPERATION OF PLANT	163,511	84,385	247,896		247,896
8.01	0801 OPERATION OF PLANT-HOSPITAL		726,254	726,254		726,254
8.03	0803 OPERATION OF PLANT-TLMAB		198,393	198,393		198,393
9	0900 LAUNDRY & LINEN SERVICE		113,891	113,891		113,891
10	1000 HOUSEKEEPING	275,776	87,523	363,299		363,299
11	1100 DIETARY	458,768	297,566	756,334	-320,861	435,473
12	1200 CAFETERIA				320,861	320,861
14	1400 NURSING ADMINISTRATION	541,644	35,697	577,341		577,341
15	1500 CENTRAL SERVICES & SUPPLY	68,726	51,191	119,917		119,917
16	1600 PHARMACY	141,464	1,875,906	2,017,370		2,017,370
17	1700 MEDICAL RECORDS & LIBRARY	189,378	30,011	219,389		219,389
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	1,217,726	481,580	1,699,306	-95,277	1,604,029
26	2600 INTENSIVE CARE UNIT	135,855	38,592	174,447		174,447
33	3300 NURSERY	132,883	14,033	146,916	-40,087	106,829
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	722,687	888,943	1,611,630	-6,482	1,605,148
39	3900 DELIVERY ROOM & LABOR ROOM				135,364	135,364
41	4100 RADIOLOGY-DIAGNOSTIC	572,509	1,563,659	2,136,168		2,136,168
42	4200 RADIOLOGY-THERAPEUTIC	34,168	143,009	177,177		177,177
43	4300 RADIOISOTOPE	157,557	303,194	460,751		460,751
44	4400 LABORATORY	602,846	1,015,657	1,618,503		1,618,503
50	5000 PHYSICAL THERAPY	289,172	48,847	338,019		338,019
51	5100 OCCUPATIONAL THERAPY	73,038	2,254	75,292		75,292
52	5200 SPEECH PATHOLOGY	77,608	3,629	81,237		81,237
53	5300 ELECTROCARDIOLOGY	32,945	42,117	75,062		75,062
55.30	5530 IMPL. DEV. CHARGED TO PATIENT				6,482	6,482
56	5600 DRUGS CHARGED TO PATIENTS					
59	3480 CAT SCAN	154,266	563,421	717,687		717,687
59.01	3230 ONCOLOGY	89,617	105,959	195,576		195,576
59.02	3160 CARDIOPULMONARY	320,991	72,284	393,275		393,275
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	77,891	13,426	91,317		91,317
61	6100 EMERGENCY	834,923	851,657	1,686,580		1,686,580
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
62.01	6201 OBSERVATION BEDS (DISTINCT PART)	159,392	5,404	164,796		164,796
	OTHER REIMBURS COST CNTRS					
66	6600 DURABLE MEDICAL EQUIP-RENTED	85,737	52,367	138,104		138,104
71	7100 HOME HEALTH AGENCY	405,038	129,932	534,970		534,970
	SPEC PURPOSE COST CENTERS					
95	SUBTOTALS	10,060,622	17,585,958	27,646,580	-0-	27,646,580
	NONREIMBURS COST CENTERS					
98	9800 PHYSICIANS' PRIVATE OFFICES					
98.01	9801 DR. WHITT	388,483	144,512	532,995		532,995
98.02	9802 TLMOB		5,901	5,901		5,901
100	7951 OCC MED	71	355	426		426
100.01	7950 VENDING ROOM					
101	TOTAL	10,449,176	17,736,726	28,185,902	-0-	28,185,902

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
I 15-1312 I FROM 1/ 1/2010 I WORKSHEET A
I I TO 12/31/2010 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	-6,667	156,490
1.01	0101 OLD CAP REL COSTS-BLDG & FIXT-HOSP	30,425	3,391,221
1.03	0103 OLD CAP REL COSTS-BLDG & FIXT-TLMAB	-22,380	926,539
5	0500 EMPLOYEE BENEFITS		2,004,158
6	0600 ADMINISTRATIVE & GENERAL	-115,775	3,196,878
8	0800 OPERATION OF PLANT	-64,082	183,814
8.01	0801 OPERATION OF PLANT-HOSPITAL		726,254
8.03	0803 OPERATION OF PLANT-TLMAB		198,393
9	0900 LAUNDRY & LINEN SERVICE		113,891
10	1000 HOUSEKEEPING		363,299
11	1100 DIETARY	-226,493	208,980
12	1200 CAFETERIA	-90,875	229,986
14	1400 NURSING ADMINISTRATION		577,341
15	1500 CENTRAL SERVICES & SUPPLY	-63,621	56,296
16	1600 PHARMACY	-65,311	1,952,059
17	1700 MEDICAL RECORDS & LIBRARY	-339	219,050
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-274,428	1,329,601
26	2600 INTENSIVE CARE UNIT		174,447
33	3300 NURSERY		106,829
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM	-569,075	1,036,073
39	3900 DELIVERY ROOM & LABOR ROOM		135,364
41	4100 RADIOLOGY-DIAGNOSTIC	-700,670	1,435,498
42	4200 RADIOLOGY-THERAPEUTIC		177,177
43	4300 RADIOISOTOPE		460,751
44	4400 LABORATORY	-17,760	1,600,743
50	5000 PHYSICAL THERAPY		338,019
51	5100 OCCUPATIONAL THERAPY		75,292
52	5200 SPEECH PATHOLOGY		81,237
53	5300 ELECTROCARDIOLOGY		75,062
55.30	5530 IMPL. DEV. CHARGED TO PATIENT		6,482
56	5600 DRUGS CHARGED TO PATIENTS		
59	3480 CAT SCAN	-291,000	426,687
59.01	3230 ONCOLOGY	-78,000	117,576
59.02	3160 CARDIOPULMONARY	-4,055	389,220
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC		91,317
61	6100 EMERGENCY	-4,550	1,682,030
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
62.01	6201 OBSERVATION BEDS (DISTINCT PART)		164,796
	OTHER REIMBURS COST CNTRS		
66	6600 DURABLE MEDICAL EQUIP-RENTED		138,104
71	7100 HOME HEALTH AGENCY		534,970
	SPEC PURPOSE COST CENTERS		
95	SUBTOTALS	-2,564,656	25,081,924
	NONREIMBURS COST CENTERS		
98	9800 PHYSICIANS' PRIVATE OFFICES		
98.01	9801 DR. WHITT		532,995
98.02	9802 TLMOB		5,901
100	7951 OCC MED		426
100.01	7950 VENDING ROOM		
101	TOTAL	-2,564,656	25,621,246

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
 I 15-1312 I FROM 1/ 1/2010 I NOT A CMS WORKSHEET
 I I TO 12/31/2010 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
1	OLD CAP REL COSTS-BLDG & FIXT	0100	
1.01	OLD CAP REL COSTS-BLDG & FIXT-HOSP	0101	OLD CAP REL COSTS-BLDG & FIXT
1.03	OLD CAP REL COSTS-BLDG & FIXT-TLMAB	0103	OLD CAP REL COSTS-BLDG & FIXT
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
8.01	OPERATION OF PLANT-HOSPITAL	0801	OPERATION OF PLANT
8.03	OPERATION OF PLANT-TLMAB	0803	OPERATION OF PLANT
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
33	NURSERY	3300	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
39	DELIVERY ROOM & LABOR ROOM	3900	
41	RADIOLOGY-DIAGNOSTIC	4100	
42	RADIOLOGY-THERAPEUTIC	4200	
43	RADIOISOTOPE	4300	
44	LABORATORY	4400	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
55.30	IMPL. DEV. CHARGED TO PATIENT	5530	IMPL. DEV. CHARGED TO PATIENT
56	DRUGS CHARGED TO PATIENTS	5600	
59	CAT SCAN	3480	ONCOLOGY
59.01	ONCOLOGY	3230	CAT SCAN
59.02	CARDIOPULMONARY	3160	CARDIOPULMONARY
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
62.01	OBSERVATION BEDS (DISTINCT PART)	6201	OBSERVATION BEDS (NON-DISTINCT PART)
	OTHER REIMBURS COST		
66	DURABLE MEDICAL EQUIP-RENTED	6600	
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
98	PHYSICIANS' PRIVATE OFFICES	9800	
98.01	DR. WHITT	9801	PHYSICIANS' PRIVATE OFFICES
98.02	TLMOB	9802	PHYSICIANS' PRIVATE OFFICES
100	OCC MED	7951	OTHER NONREIMBURSABLE COST CENTERS
100.01	VENDING ROOM	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151312	FROM 1/ 1/2010	5/20/2011
	TO 12/31/2010	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1)	COST CENTER	LINE NO	SALARY	OTHER
	1	2	3	4	5
1 CAFETERIA RECLASS	A	CAFETERIA	12	189,365	131,496
2 OB, NURSERY, & LD	B	NURSERY	33		4,451
3		DELIVERY ROOM & LABOR ROOM	39	111,942	23,422
4 IMPLANTABLE DEVICE	C	IMPL. DEV. CHARGED TO PATIENT	55.30		6,482
36 TOTAL RECLASSIFICATIONS				301,307	165,851

(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
151312	FROM 1/ 1/2010	5/20/2011
	TO 12/31/2010	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE		DECREASE			A-7 REF 10
	(1)	COST CENTER	LINE NO	SALARY	OTHER	
	1	6	7	8	9	
1 CAFETERIA RECLASS	A	DIETARY	11	189,365	131,496	
2 OB, NURSERY, & LD	B	ADULTS & PEDIATRICS	25	67,404	27,873	
3		NURSERY	33	44,538		
4 IMPLANTABLE DEVICE	C	OPERATING ROOM	37		6,482	
36 TOTAL RECLASSIFICATIONS				301,307	165,851	

(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
151312	FROM 1/ 1/2010	5/20/2011
	TO 12/31/2010	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: A
 EXPLANATION : CAFETERIA RECLASS

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	CAFETERIA	320,861	11	DIETARY	320,861
TOTAL RECLASSIFICATIONS FOR CODE A		320,861			

RECLASS CODE: B
 EXPLANATION : OB, NURSERY, & LD

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	NURSERY	4,451	25	ADULTS & PEDIATRICS	95,277
2.00	DELIVERY ROOM & LABOR ROOM	135,364	33	NURSERY	44,538
TOTAL RECLASSIFICATIONS FOR CODE B		139,815			139,815

RECLASS CODE: C
 EXPLANATION : IMPLANTABLE DEVICE

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	IMPL. DEV. CHARGED TO PATIENT	6,482	37	OPERATING ROOM	6,482
TOTAL RECLASSIFICATIONS FOR CODE C		6,482			

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	954,570						954,570	
2	LAND IMPROVEMENTS	1,845,689						1,845,689	
3	BUILDINGS & FIXTURE	31,806,357	225,149			225,149		32,031,506	
4	BUILDING IMPROVEMEN								
5	FIXED EQUIPMENT								
6	MOVABLE EQUIPMENT	7,649,782	33,440			33,440	4,147	7,679,075	
7	SUBTOTAL	42,256,398	258,589			258,589	4,147	42,510,840	
8	RECONCILING ITEMS								
9	TOTAL	42,256,398	258,589			258,589	4,147	42,510,840	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION	GROSS ASSETS 1	COMPUTATION OF RATIOS CAPITIALIZED GROSS ASSETS		RATIO 4	ALLOCATION OF OTHER CAPITAL OTHER CAPITAL RELATED COSTS			TOTAL 8
		LEASES 2	FOR RATIO 3		INSURANCE 5	TAXES 6	OTHER CAPITAL RELATED COSTS 7	
* OLD CAP REL COSTS-BL								
1 01 OLD CAP REL COSTS-BL								
1 03 OLD CAP REL COSTS-BL								
5 TOTAL				1.000000				

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13			
* OLD CAP REL COSTS-BL	163,157			-6,667			156,490	
1 01 OLD CAP REL COSTS-BL	1,504,763		-67,103			1,953,561	3,391,221	
1 03 OLD CAP REL COSTS-BL	440,192		-22,380			508,727	926,539	
5 TOTAL	2,108,112		-89,483	-6,667		2,462,288	4,474,250	

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

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13			
* OLD CAP REL COSTS-BL	163,157						163,157	
1 01 OLD CAP REL COSTS-BL	1,407,235					1,953,561	3,360,796	
1 03 OLD CAP REL COSTS-BL	440,192					508,727	948,919	
5 TOTAL	2,010,584					2,462,288	4,472,872	

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO:
I 15-1312
I

I PERIOD: I PREPARED 5/20/2011
I FROM 1/ 1/2010 I WORKSHEET A-8
I TO 12/31/2010 I

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON		WKST. A-7 REF. 5
			WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED	COST CENTER	
	1	2	3	LINE NO	
1 INVST INCOME-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3 INVST INCOME-NEW BLDGS AND FIXTURES			**COST CENTER DELETED**	3	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			**COST CENTER DELETED**	4	
5 INVESTMENT INCOME-OTHER					
6 TRADE, QUANTITY AND TIME DISCOUNTS					
7 REFUNDS AND REBATES OF EXPENSES					
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9 TELEPHONE SERVICES					
10 TELEVISION AND RADIO SERVICE					
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-1,763,843			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS					
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					
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		**COST CENTER DELETED**	49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28 UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			**COST CENTER DELETED**	3	
32 DEPRECIATION-NEW MOVABLE EQUIP			**COST CENTER DELETED**	4	
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34 PHYSICIANS' ASSISTANT					
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		OCCUPATIONAL THERAPY	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
37 PHYSICIAN RECRUITMENT	A	-6,375	ADMINISTRATIVE & GENERAL	6	
38 MISCELLANEOUS REVENUE	B	-3,212	ADMINISTRATIVE & GENERAL	6	
39 MISCELLANEOUS REVENUE	B	-19,105	DIETARY	11	
40 ADVERTISING A&G	A	-92,009	ADMINISTRATIVE & GENERAL	6	
41 IHHA LOBBYING	A	-683	ADMINISTRATIVE & GENERAL	6	
42 CRNA EXPENSE	A	-170,475	OPERATING ROOM	37	
43 INTEREST INCOME	B	-67,103	OLD CAP REL COSTS-BLDG &	1.01	11
44 INTEREST INCOME	B	-22,380	OLD CAP REL COSTS-BLDG &	1.03	11
45					
46 SAFE SITTER	B	-660	ADMINISTRATIVE & GENERAL	6	
47 DOCTORS APPLICATION FEE	B	-5,225	ADMINISTRATIVE & GENERAL	6	
48 O'CONNOR RENTAL	B	-4,800	ADMINISTRATIVE & GENERAL	6	
49 GROUP PURCHASE REBATE	B	-1,196	ADMINISTRATIVE & GENERAL	6	
49.01 CPR	B	-1,593	ADMINISTRATIVE & GENERAL	6	
49.02 CASH SHORT OR LONG	B	358	ADMINISTRATIVE & GENERAL	6	
49.03 WIC PROGRAM	A	-207,349	DIETARY	11	
49.04 DIETARY MISC REVENUE	B	-39	DIETARY	11	
49.05 CAFETERIA	B	-90,875	CAFETERIA	12	
49.06 MATERIALS MANAGEMENT	B	-63,621	CENTRAL SERVICES & SUPPLY	15	
49.07 SALE OF PHARMACY	B	-65,311	PHARMACY	16	
49.08 SALE OF MEDICAL RECORDS	B	-339	MEDICAL RECORDS & LIBRARY	17	
49.09 SALE OF XRAY FILM	B	-670	RADIOLOGY-DIAGNOSTIC	41	
49.10 ENPC EMERG NURSE	B	-4,550	EMERGENCY	61	
49.11 COMMUNITY HEALTH PROGRAM	B	-280	ADMINISTRATIVE & GENERAL	6	
49.12 OLD HOSPITAL-MAINTENANCE EXPENSE	A	-64,082	OPERATION OF PLANT	8	
49.13 ORGANIZATION DONATION	A	-100	ADMINISTRATIVE & GENERAL	6	
49.14 LOSS ON ABANDONMENT	A	97,528	OLD CAP REL COSTS-BLDG &	1.01	9
49.15 OLD HOSPITAL-INSURANCE EXPENSE	A	-6,667	OLD CAP REL COSTS-BLDG &	1	12
49.16					
50 TOTAL (SUM OF LINES 1 THRU 49)		-2,564,656			

(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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
 I 15-1312 I FROM 1/ 1/2010 I WORKSHEET A-8-2
 I I TO 12/31/2010 I GROUP 1

LINE NO.	WKSHT A	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	PHYSICIAN FEES -OB	274,428	274,428					
2	37	PHYSICIAN FEES -OR	118,000	118,000					
3	37	PHYSICIAN FEES ANEST	280,600	280,600					
4	41	PHYSICIAN FEES -RADI	700,000	700,000					
5	44	PHYSICIAN FEES -LAB	48,000	17,760	30,240				
6	59	PHYSICIAN FEES -CT S	291,000	291,000					
7	59	1 PHYSICIAN FEES -ONOC	78,000	78,000					
8	59	2 PURCHASED SERVICES -CARD	4,055	4,055					
9	61	PHYSICIAN FEES -EMER	662,000		662,000				
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL	2,456,083	1,763,843	692,240				

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)	66
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	325
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	4.85
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5

9	TOTAL HOURS WORKED		512.00	1416.60	
10	AHSEA (SEE INSTRUCTIONS)		64.41	52.19	
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	32.21	32.21	26.10	
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)	32,978
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	73,932
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	106,910
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	106,910

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)	106,910

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)	2,126
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	8,483
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	10,609
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	1,896
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	12,505
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	

PHYSICAL THERAPY

31 SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
 32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2,
 LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)
 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL 12,505
 EXPENSE (LINE 28)
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL
 EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL
 EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

	1	2	3	4	5
	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) 106,910
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM
 PART III, LINE 33, 34, OR 35) 12,505
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES
 (FROM PART IV, LINES 44, 45, OR 46)
 60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)

PHYSICAL THERAPY

61 EQUIPMENT COST (SEE INSTRUCTIONS)

62 SUPPLIES (SEE INSTRUCTIONS)

63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 119,415

64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 36,858

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

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

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS) 36,858

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) 36,858

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)

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)

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)	
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	4.85
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5

9	TOTAL HOURS WORKED		19.00		
10	AHSEA (SEE INSTRUCTIONS)		54.88		
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	27.44	27.44		
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)	1,043
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)	1,043
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	1,043

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)	54.89
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	42,814
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	42,814

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

OCCUPATIONAL THERAPY

- 31 SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
- 32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)
- 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)
- 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
- 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

- 57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 42,814
- 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)
- 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)
- 60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)

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

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011 I 15-1312 I FROM 1/ 1/2010 I WORKSHEET A-8-4 I I TO 12/31/2010 I PARTS I - VII

OCCUPATIONAL THERAPY

61 EQUIPMENT COST (SEE INSTRUCTIONS)
62 SUPPLIES (SEE INSTRUCTIONS)
63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 42,814
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 120
65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)

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

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS) 120
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) 120
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)
69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
69.31 EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
 I 15-1312 I FROM 1/ 1/2010 I NOT A CMS WORKSHEET
 I I TO 12/31/2010 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
1	OLD CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEET	ENTERED
1.01	OLD CAP REL COSTS-BLDG & FIXT-HOSP	21	SQUARE	FEET	ENTERED
1.03	OLD CAP REL COSTS-BLDG & FIXT-TLMAB	23	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS SALARIES		NOT ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	1	SQUARE	FEET	ENTERED
8.01	OPERATION OF PLANT-HOSPITAL	21	SQUARE	FEET	ENTERED
8.03	OPERATION OF PLANT-TLMAB	23	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	9	HOURS OF	SERVICE	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	12	FTES		ENTERED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED	REQUIS.	ENTERED
16	PHARMACY	15	COSTED	REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME	SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO:
I 15-1312
II PERIOD:
I FROM 1/ 1/2010
I TO 12/31/2010I PREPARED 5/20/2011
I WORKSHEET B
I PART I

COST CENTER DESCRIPTION		NET EXPENSES FOR COST ALLOCATION	OLD CAP REL C OSTS-BLDG &	OLD CAP REL C OSTS-BLDG &	OLD CAP REL C OSTS-BLDG &	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIV E & GENERAL
		0	1	1.01	1.03	5	5a.00	6
	GENERAL SERVICE COST CNTR							
001	OLD CAP REL COSTS-BLDG &	156,490	156,490					
001 01	OLD CAP REL COSTS-BLDG &	3,391,221		3,391,221				
001 03	OLD CAP REL COSTS-BLDG &	926,539			926,539			
005	EMPLOYEE BENEFITS	2,004,158				2,004,158		
006	ADMINISTRATIVE & GENERAL	3,196,878	17,855	218,752	193,360	378,334	4,005,179	4,005,179
008	OPERATION OF PLANT	183,814				31,630	215,444	39,919
008 01	OPERATION OF PLANT-HOSPIT	726,254	5,046	166,674			897,974	166,383
008 03	OPERATION OF PLANT-TLMAB	198,393	1,386				223,640	41,438
009	LAUNDRY & LINEN SERVICE	113,891					113,891	21,103
010	HOUSEKEEPING	363,299	3,661	115,828			538,797	99,832
011	DIETARY	208,980	3,294			56,706	52,114	321,094
012	CAFETERIA	229,986	3,225			55,517	36,631	325,359
014	NURSING ADMINISTRATION	577,341	237			4,088	104,777	686,443
015	CENTRAL SERVICES & SUPPLY	56,296	1,938	64,025			13,295	135,554
016	PHARMACY	1,952,059	2,405	79,438			27,365	2,061,267
017	MEDICAL RECORDS & LIBRARY	219,050	2,176				37,455	36,634
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	1,329,601	23,236	767,479			222,522	2,342,838
026	INTENSIVE CARE UNIT	174,447	2,783	91,933			26,280	295,443
033	NURSERY	106,829	561	18,514			17,090	142,994
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	1,036,073	14,940	493,502			139,799	1,684,314
039	DELIVERY ROOM & LABOR ROO	135,364	1,066	35,205			21,654	193,289
041	RADIOLOGY-DIAGNOSTIC	1,435,498	9,450	312,144			110,748	1,867,840
042	RADIOLOGY-THERAPEUTIC	177,177	567	18,742			6,610	203,096
043	RADIOISOTOPE	460,751	498	16,462			30,478	508,189
044	LABORATORY	1,600,743	3,903	128,916			116,616	1,850,178
050	PHYSICAL THERAPY	338,019	3,569	117,881			55,938	515,407
051	OCCUPATIONAL THERAPY	75,292					14,129	89,421
052	SPEECH PATHOLOGY	81,237					15,013	96,250
053	ELECTROCARDIOLOGY	75,062	583	19,244			6,373	101,262
055 30	IMPL. DEV. CHARGED TO PAT	6,482						6,482
056	DRUGS CHARGED TO PATIENTS							
059	CAT SCAN	426,687	682	22,527			29,842	479,738
059 01	ONCOLOGY	117,576	2,586	85,412			17,336	222,910
059 02	CARDIOPULMONARY	389,220	2,195	72,507			62,093	526,015
	OUTPAT SERVICE COST CNTRS							
060	CLINIC	91,317					15,067	106,384
061	EMERGENCY	1,682,030	11,191	369,648			161,510	2,224,379
062	OBSERVATION BEDS (NON-DIS							
062 01	OBSERVATION BEDS (DISTINC	164,796	5,340	176,388			30,833	377,357
	OTHER REIMBURS COST CNTRS							
066	DURABLE MEDICAL EQUIP-REN	138,104	2,369				40,782	16,585
071	HOME HEALTH AGENCY	534,970	1,298				22,340	78,352
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	25,081,924	128,040	3,391,221	436,771	1,928,995	24,488,543	3,795,303
	NONREIMBURS COST CENTERS							
098	PHYSICIANS' PRIVATE OFFIC		5,478					
098 01	DR. WHITT	532,995	2,424				94,303	99,781
098 02	TLMOB	5,901	20,479				41,733	652,301
100	OCC MED	426					352,544	378,924
100 01	VENDING ROOM		69				14	440
101	CROSS FOOT ADJUSTMENT							82
102	NEGATIVE COST CENTER							233
103	TOTAL	25,621,246	156,490	3,391,221	926,539	2,004,158	25,621,246	4,005,179

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
 I 15-1312 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	OPERATION OF PLANT	OPERATION OF PLANT-HOSPIT	OPERATION OF PLANT-TLMAB	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA
	8	8.01	8.03	9	10	11	12
001 GENERAL SERVICE COST CNTR							
001 01 OLD CAP REL COSTS-BLDG &							
001 03 OLD CAP REL COSTS-BLDG &							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
008 OPERATION OF PLANT	255,363						
008 01 OPERATION OF PLANT-HOSPIT	9,295	1,073,652					
008 03 OPERATION OF PLANT-TLMAB	2,553		267,631				
009 LAUNDRY & LINEN SERVICE					134,994		
010 HOUSEKEEPING	6,744	41,373	1,004	600	688,350		
011 DIETARY	6,068		21,395	517	39,760	448,329	
012 CAFETERIA	5,940		20,947				412,531
014 NURSING ADMINISTRATION	437		1,542				23,304
015 CENTRAL SERVICES & SUPPLY	3,570	22,869			3,313		4,646
016 PHARMACY	4,430	28,375			24,574		7,488
017 MEDICAL RECORDS & LIBRARY	4,008		14,132				12,974
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	42,800	274,138		63,313	115,691	438,523	78,291
026 INTENSIVE CARE UNIT	5,127	32,838		3,258	72,066	9,806	8,946
033 NURSERY	1,032	6,613		1,341			4,918
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	27,520	176,276		27,203	82,834		31,880
039 DELIVERY ROOM & LABOR ROO	1,963	12,575		1,702			4,572
041 RADIOLOGY-DIAGNOSTIC	17,407	111,496		8,267	30,372		30,619
042 RADIOLOGY-THERAPEUTIC	1,045	6,695					2,471
043 RADIOISOTOPE	918	5,880					5,536
044 LABORATORY	7,189	46,048		414	31,201		39,293
050 PHYSICAL THERAPY	6,574	42,106		956	19,880		13,098
051 OCCUPATIONAL THERAPY							2,026
052 SPEECH PATHOLOGY							2,372
053 ELECTROCARDIOLOGY	1,073	6,874					2,842
055 30 IMPL. DEV. CHARGED TO PAT							
056 DRUGS CHARGED TO PATIENTS							
059 CAT SCAN	1,256	8,047					6,277
059 01 ONCOLOGY	4,763	30,509		493			5,610
059 02 CARDIOPULMONARY	4,043	25,899		931	18,500		21,723
OUTPAT SERVICE COST CNTRS							
060 CLINIC				708	27,059		9,070
061 EMERGENCY	20,613	132,036		24,579	72,342		44,829
062 OBSERVATION BEDS (NON-DIS							
062 01 OBSERVATION BEDS (DISTINC	9,836	63,005					9,638
OTHER REIMBURS COST CNTRS							
066 DURABLE MEDICAL EQUIP-REN	4,364		15,387				5,313
071 HOME HEALTH AGENCY	2,390		8,429		10,216		25,602
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	202,958	1,073,652	82,836	134,282	547,808	448,329	403,338
NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC	10,091		35,581		40,865		
098 01 DR. WHITT	4,465		15,746	712	9,388		9,193
098 02 TLMOB	37,722		133,020		90,289		
100 OCC MED							
100 01 VENDING ROOM	127		448				
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	255,363	1,073,652	267,631	134,994	688,350	448,329	412,531

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
 I 15-1312 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	14	15	16	17	25	26	27
001 GENERAL SERVICE COST CNTR							
001 01 OLD CAP REL COSTS-BLDG &							
001 03 OLD CAP REL COSTS-BLDG &							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
008 OPERATION OF PLANT							
008 01 OPERATION OF PLANT-HOSPIT							
008 03 OPERATION OF PLANT-TLMAB							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING							
011 DIETARY							
012 CAFETERIA							
014 NURSING ADMINISTRATION	838,915						
015 CENTRAL SERVICES & SUPPLY		195,068					
016 PHARMACY		2,108	2,510,168				
017 MEDICAL RECORDS & LIBRARY			357	381,504			
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	314,080	12,494		71,898	4,188,164		4,188,164
026 INTENSIVE CARE UNIT	35,585	1,653		605	520,069		520,069
033 NURSERY	15,175	1,575		3,066	203,209		203,209
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	126,808	40,639		28,706	2,538,261		2,538,261
039 DELIVERY ROOM & LABOR ROO	19,848	1,996		3,883	275,642		275,642
041 RADIOLOGY-DIAGNOSTIC		2,252		136,041	2,550,380		2,550,380
042 RADIOLOGY-THERAPEUTIC		403			251,341		251,341
043 RADIOISOTOPE		767			615,451		615,451
044 LABORATORY		84,075		24,183	2,425,395		2,425,395
050 PHYSICAL THERAPY		1,403		4,053	698,975		698,975
051 OCCUPATIONAL THERAPY	8,024	195			116,235		116,235
052 SPEECH PATHOLOGY		7			116,463		116,463
053 ELECTROCARDIOLOGY	11,257	1,448			143,519		143,519
055 30 IMPL. DEV. CHARGED TO PAT					7,683		7,683
056 DRUGS CHARGED TO PATIENTS			2,510,168		2,510,168		2,510,168
059 CAT SCAN		2,802			587,009		587,009
059 01 ONCOLOGY	22,296	1,590		59	329,532		329,532
059 02 CARDIOPULMONARY	86,388	5,623		3,783	790,369		790,369
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC		668		3,912	167,513		167,513
061 EMERGENCY	178,334	19,216		101,315	3,229,792		3,229,792
062 OBSERVATION BEDS (NON-DIS							
062 01 OBSERVATION BEDS (DISTINC		879			530,634		530,634
066 OTHER REIMBURS COST CNTRS							
066 DURABLE MEDICAL EQUIP-REN	21,120	6,178			286,859		286,859
071 HOME HEALTH AGENCY		1,444			803,061		803,061
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	838,915	189,772	2,510,168	381,504	23,885,724		23,885,724
098 NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC					204,806		204,806
098 01 DR. WHITT		5,296			817,964		817,964
098 02 TLMOB					710,165		710,165
100 OCC MED					522		522
100 01 VENDING ROOM					2,065		2,065
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	838,915	195,068	2,510,168	381,504	25,621,246		25,621,246

ALLOCATION OF OLD CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	DIR ASSGND OLD CAPITAL REL COSTS	OLD CAP REL C OSTS-BLDG &	OLD CAP REL C OSTS-BLDG &	OLD CAP REL C OSTS-BLDG &	SUBTOTAL	EMPLOYEE BENE FITS	ADMINISTRATIV E & GENERAL
	0	1	1.01	1.03	4a	5	6
001 GENERAL SERVICE COST CNTR							
001 01 OLD CAP REL COSTS-BLDG &							
001 03 OLD CAP REL COSTS-BLDG &							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL		17,855	218,752	193,360	429,967		429,967
008 OPERATION OF PLANT							4,285
008 01 OPERATION OF PLANT-HOSPIT		5,046	166,674		171,720		17,862
008 03 OPERATION OF PLANT-TLMAB		1,386		23,861	25,247		4,448
009 LAUNDRY & LINEN SERVICE							2,265
010 HOUSEKEEPING		3,661	115,828	2,662	122,151		10,717
011 DIETARY		3,294		56,706	60,000		6,387
012 CAFETERIA		3,225		55,517	58,742		6,472
014 NURSING ADMINISTRATION		237		4,088	4,325		13,654
015 CENTRAL SERVICES & SUPPLY		1,938	64,025		65,963		2,696
016 PHARMACY		2,405	79,438		81,843		41,001
017 MEDICAL RECORDS & LIBRARY		2,176		37,455	39,631		5,874
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS		23,236	767,479		790,715		46,603
026 INTENSIVE CARE UNIT		2,783	91,933		94,716		5,877
033 NURSERY		561	18,514		19,075		2,844
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		14,940	493,502		508,442		33,503
039 DELIVERY ROOM & LABOR ROO		1,066	35,205		36,271		3,845
041 RADIOLOGY-DIAGNOSTIC		9,450	312,144		321,594		37,153
042 RADIOLOGY-THERAPEUTIC		567	18,742		19,309		4,040
043 RADIOISOTOPE		498	16,462		16,960		10,108
044 LABORATORY		3,903	128,916		132,819		36,802
050 PHYSICAL THERAPY		3,569	117,881		121,450		10,252
051 OCCUPATIONAL THERAPY							1,779
052 SPEECH PATHOLOGY							1,915
053 ELECTROCARDIOLOGY		583	19,244		19,827		2,014
055 30 IMPL. DEV. CHARGED TO PAT							129
056 DRUGS CHARGED TO PATIENTS							
059 CAT SCAN		682	22,527		23,209		9,542
059 01 ONCOLOGY		2,586	85,412		87,998		4,434
059 02 CARDIOPULMONARY		2,195	72,507		74,702		10,463
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC							2,116
061 EMERGENCY		11,191	369,648		380,839		44,245
062 OBSERVATION BEDS (NON-DIS							
062 01 OBSERVATION BEDS (DISTINC		5,340	176,388		181,728		7,506
066 OTHER REIMBURS COST CNTRS							
066 DURABLE MEDICAL EQUIP-REN		2,369		40,782	43,151		3,935
071 HOME HEALTH AGENCY		1,298		22,340	23,638		12,670
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS		128,040	3,391,221	436,771	3,956,032		407,436
098 NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC		5,478		94,303	99,781		1,985
098 01 DR. WHITT		2,424		41,733	44,157		12,975
098 02 TLMOB		20,479		352,544	373,023		7,537
100 OCC MED							9
100 01 VENDING ROOM		69		1,188	1,257		25
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		156,490	3,391,221	926,539	4,474,250		429,967

ALLOCATION OF OLD CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	OPERATION OF PLANT	OPERATION OF PLANT-HOSPIT	OPERATION OF PLANT-TLMAB	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA
	8	8.01	8.03	9	10	11	12
GENERAL SERVICE COST CNTR							
001 OLD CAP REL COSTS-BLDG &							
001 01 OLD CAP REL COSTS-BLDG &							
001 03 OLD CAP REL COSTS-BLDG &							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
008 OPERATION OF PLANT	4,285						
008 01 OPERATION OF PLANT-HOSPIT	156	189,738					
008 03 OPERATION OF PLANT-TLMAB	43		29,738				
009 LAUNDRY & LINEN SERVICE				2,265			
010 HOUSEKEEPING	113	7,312	112	10	140,415		
011 DIETARY	102		2,377	9	8,111	76,986	
012 CAFETERIA	100		2,328				67,642
014 NURSING ADMINISTRATION	7		171				3,821
015 CENTRAL SERVICES & SUPPLY	60	4,042			676		762
016 PHARMACY	74	5,014			5,013		1,228
017 MEDICAL RECORDS & LIBRARY	67		1,570				2,127
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	719	48,445		1,061	23,598	75,302	12,837
026 INTENSIVE CARE UNIT	86	5,803		55	14,700	1,684	1,467
033 NURSERY	17	1,169		23			806
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	462	31,152		456	16,897		5,227
039 DELIVERY ROOM & LABOR ROO	33	2,222		29			750
041 RADIOLOGY-DIAGNOSTIC	292	19,704		139	6,196		5,021
042 RADIOLOGY-THERAPEUTIC	18	1,183					405
043 RADIOISOTOPE	15	1,039					908
044 LABORATORY	121	8,138		7	6,365		6,443
050 PHYSICAL THERAPY	110	7,441		16	4,055		2,148
051 OCCUPATIONAL THERAPY							332
052 SPEECH PATHOLOGY							389
053 ELECTROCARDIOLOGY	18	1,215					466
055 30 IMPL. DEV. CHARGED TO PAT							
056 DRUGS CHARGED TO PATIENTS							
059 CAT SCAN	21	1,422					1,029
059 01 ONCOLOGY	80	5,392		8			920
059 02 CARDIOPULMONARY	68	4,577		16	3,774		3,562
OUTPAT SERVICE COST CNTRS							
060 CLINIC				12	5,520		1,487
061 EMERGENCY	346	23,334		412	14,757		7,351
062 OBSERVATION BEDS (NON-DIS							
062 01 OBSERVATION BEDS (DISTINC	165	11,134					1,580
OTHER REIMBURS COST CNTRS							
066 DURABLE MEDICAL EQUIP-REN	73		1,710				871
071 HOME HEALTH AGENCY	40		937		2,084		4,198
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	3,406	189,738	9,205	2,253	111,746	76,986	66,135
NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC	169		3,954		8,336		
098 01 DR. WHITT	75		1,750	12	1,915		1,507
098 02 TLMOB	633		14,779		18,418		
100 OCC MED							
100 01 VENDING ROOM	2		50				
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	4,285	189,738	29,738	2,265	140,415	76,986	67,642

ALLOCATION OF OLD CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
 I 15-1312 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART II

COST CENTER DESCRIPTION	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	14	15	16	17	25	26	27
001 GENERAL SERVICE COST CNTR							
001 01 OLD CAP REL COSTS-BLDG &							
001 03 OLD CAP REL COSTS-BLDG &							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
008 OPERATION OF PLANT							
008 01 OPERATION OF PLANT-HOSPIT							
008 03 OPERATION OF PLANT-TLMAB							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING							
011 DIETARY							
012 CAFETERIA							
014 NURSING ADMINISTRATION	21,978						
015 CENTRAL SERVICES & SUPPLY		74,199					
016 PHARMACY		802	134,975				
017 MEDICAL RECORDS & LIBRARY		136		49,405			
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	8,229	4,752		9,311	1,021,572		1,021,572
026 INTENSIVE CARE UNIT	932	629		78	126,027		126,027
033 NURSERY	398	599		397	25,328		25,328
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	3,322	15,458		3,717	618,636		618,636
039 DELIVERY ROOM & LABOR ROO	520	759		503	44,932		44,932
041 RADIOLOGY-DIAGNOSTIC		857		17,617	408,573		408,573
042 RADIOLOGY-THERAPEUTIC		153			25,108		25,108
043 RADIOISOTOPE		292			29,322		29,322
044 LABORATORY		31,980		3,132	225,807		225,807
050 PHYSICAL THERAPY		534		525	146,531		146,531
051 OCCUPATIONAL THERAPY	210	74			2,395		2,395
052 SPEECH PATHOLOGY		2			2,306		2,306
053 ELECTROCARDIOLOGY	295	551			24,386		24,386
055 30 IMPL. DEV. CHARGED TO PAT					129		129
056 DRUGS CHARGED TO PATIENTS			134,975		134,975		134,975
059 CAT SCAN		1,066			36,289		36,289
059 01 ONCOLOGY	584	605		8	100,029		100,029
059 02 CARDIOPULMONARY	2,263	2,139		490	102,054		102,054
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC		254		507	9,896		9,896
061 EMERGENCY	4,672	7,309		13,120	496,385		496,385
062 OBSERVATION BEDS (NON-DIS							
062 01 OBSERVATION BEDS (DISTINC		334			202,447		202,447
066 OTHER REIMBURS COST CNTRS							
066 DURABLE MEDICAL EQUIP-REN	553	2,350			52,643		52,643
071 HOME HEALTH AGENCY		549			44,116		44,116
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	21,978	72,184	134,975	49,405	3,879,886		3,879,886
098 NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC					114,225		114,225
098 01 DR. WHITT		2,015			64,406		64,406
098 02 TLMOB					414,390		414,390
100 OCC MED					9		9
100 01 VENDING ROOM					1,334		1,334
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	21,978	74,199	134,975	49,405	4,474,250		4,474,250

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
 I 15-1312 I FROM 1/1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	OLD CAP REL C	OLD CAP REL C	OLD CAP REL C	EMPLOYEE BENE	RECONCILIATION	ADMINISTRATIVE & GENERAL
	OSTS-BLDG & (SQUARE FEET)	OSTS-BLDG & (SQUARE FEET)	OSTS-BLDG & (SQUARE FEET)	(GROSS SALARIES)		(ACCUM. COST)
	1	1.01	1.03	5	6a.00	6
GENERAL SERVICE COST						
001 OLD CAP REL COSTS-BLD	113,352					
001 01 OLD CAP REL COSTS-BLD		74,366				
001 03 OLD CAP REL COSTS-BLD			38,986			
005 EMPLOYEE BENEFITS				10,360,447		
006 ADMINISTRATIVE & GENE	12,933	4,797	8,136	1,955,777	-4,005,179	21,616,067
008 OPERATION OF PLANT				163,511		215,444
008 01 OPERATION OF PLANT-HO	3,655	3,655				897,974
008 03 OPERATION OF PLANT-TL	1,004		1,004			223,640
009 LAUNDRY & LINEN SERVI						113,891
010 HOUSEKEEPING	2,652	2,540	112	275,776		538,797
011 DIETARY	2,386		2,386	269,403		321,094
012 CAFETERIA	2,336		2,336	189,365		325,359
014 NURSING ADMINISTRATIO	172		172	541,644		686,443
015 CENTRAL SERVICES & SU	1,404	1,404		68,726		135,554
016 PHARMACY	1,742	1,742		141,464		2,061,267
017 MEDICAL RECORDS & LIB	1,576		1,576	189,378		295,315
INPAT ROUTINE SRVC CN						
025 ADULTS & PEDIATRICS	16,830	16,830		1,150,322		2,342,838
026 INTENSIVE CARE UNIT	2,016	2,016		135,855		295,443
033 NURSERY	406	406		88,345		142,994
ANCILLARY SRVC COST C						
037 OPERATING ROOM	10,822	10,822		722,687		1,684,314
039 DELIVERY ROOM & LABOR	772	772		111,942		193,289
041 RADIOLOGY-DIAGNOSTIC	6,845	6,845		572,509		1,867,840
042 RADIOLOGY-THERAPEUTIC	411	411		34,168		203,096
043 RADIOISOTOPE	361	361		157,557		508,189
044 LABORATORY	2,827	2,827		602,846		1,850,178
050 PHYSICAL THERAPY	2,585	2,585		289,172		515,407
051 OCCUPATIONAL THERAPY				73,038		89,421
052 SPEECH PATHOLOGY				77,608		96,250
053 ELECTROCARDIOLOGY	422	422		32,945		101,262
055 30 IMPL. DEV. CHARGED TO						6,482
056 DRUGS CHARGED TO PATI						
059 CAT SCAN	494	494		154,266		479,738
059 01 ONCOLOGY	1,873	1,873		89,617		222,910
059 02 CARDIOPULMONARY	1,590	1,590		320,991		526,015
OUTPAT SERVICE COST C						
060 CLINIC				77,891		106,384
061 EMERGENCY	8,106	8,106		834,923		2,224,379
062 OBSERVATION BEDS (NON						
062 01 OBSERVATION BEDS (DIS	3,868	3,868		159,392		377,357
OTHER REIMBURS COST C						
066 DURABLE MEDICAL EQUIP	1,716		1,716	85,737		197,840
071 HOME HEALTH AGENCY	940		940	405,038		636,960
SPEC PURPOSE COST CEN						
095 SUBTOTALS	92,744	74,366	18,378	9,971,893	-4,005,179	20,483,364
NONREIMBURS COST CENT						
098 PHYSICIANS' PRIVATE O	3,968		3,968			99,781
098 01 DR. WHITT	1,756		1,756	388,483		652,301
098 02 TLMOB	14,834		14,834			378,924
100 OCC MED				71		440
100 01 VENDING ROOM	50		50			1,257
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	156,490	3,391,221	926,539	2,004,158		4,005,179
(WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	1.380567		23.765942			
(WRKSHT B, PT I)		45.601767		.193443		.185287
105 COST TO BE ALLOCATED						429,967
(WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
(WRKSHT B, PT II)						.019891
107 COST TO BE ALLOCATED						
(WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER						
(WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
 I 15-1312 I FROM 1/ 1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	OPERATION OF PLANT	OPERATION OF PLANT-HOSPIT	OPERATION OF PLANT-TLMAB	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA
	(SQUARE FEET	(SQUARE FEET	(SQUARE FEET	(POUNDS OF) LAUNDRY	(HOURS OF) SERVICE	(MEALS)ERVED	(FTES)
	8	8.01	8.03	9	10	11	12
GENERAL SERVICE COST							
001 OLD CAP REL COSTS-BLD							
001 01 OLD CAP REL COSTS-BLD							
001 03 OLD CAP REL COSTS-BLD							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENE							
008 OPERATION OF PLANT	100,419						
008 01 OPERATION OF PLANT-HO	3,655	65,914					
008 03 OPERATION OF PLANT-TL	1,004		29,846				
009 LAUNDRY & LINEN SERVI				32,608			
010 HOUSEKEEPING	2,652	2,540	112	145	2,493		
011 DIETARY	2,386		2,386	125		20,163	
012 CAFETERIA	2,336		2,336				16,693
014 NURSING ADMINISTRATIO	172		172				943
015 CENTRAL SERVICES & SU	1,404	1,404			12		188
016 PHARMACY	1,742	1,742			89		303
017 MEDICAL RECORDS & LIB	1,576		1,576				525
025 ADULTS & PEDIATRICS	16,830	16,830		15,293	419	19,722	3,168
026 INTENSIVE CARE UNIT	2,016	2,016		787	261	441	362
033 NURSERY	406	406		324			199
037 ANCILLARY SRVC COST C							
039 OPERATING ROOM	10,822	10,822		6,571	300		1,290
041 DELIVERY ROOM & LABOR	772	772		411			185
042 RADIOLOGY-DIAGNOSTIC	6,845	6,845		1,997	110		1,239
043 RADIOLOGY-THERAPEUTIC	411	411					100
044 RADIOISOTOPE	361	361					224
044 LABORATORY	2,827	2,827		100	113		1,590
050 PHYSICAL THERAPY	2,585	2,585		231	72		530
051 OCCUPATIONAL THERAPY							82
052 SPEECH PATHOLOGY							96
053 ELECTROCARDIOLOGY	422	422					115
055 30 IMPL. DEV. CHARGED TO							
056 DRUGS CHARGED TO PATI							
059 CAT SCAN	494	494					254
059 01 ONCOLOGY	1,873	1,873		119			227
059 02 CARDIOPULMONARY	1,590	1,590		225	67		879
060 OUTPAT SERVICE COST C							
061 CLINIC				171	98		367
061 EMERGENCY	8,106	8,106		5,937	262		1,814
062 OBSERVATION BEDS (NON							
062 01 OBSERVATION BEDS (DIS	3,868	3,868					390
066 OTHER REIMBURS COST C							
071 DURABLE MEDICAL EQUIP	1,716		1,716				215
071 HOME HEALTH AGENCY	940		940		37		1,036
095 SPEC PURPOSE COST CEN							
095 SUBTOTALS	79,811	65,914	9,238	32,436	1,984	20,163	16,321
098 NONREIMBURS COST CENT							
098 PHYSICIANS' PRIVATE O	3,968		3,968		148		
098 01 DR. WHITT	1,756		1,756	172	34		372
098 02 TLMOB	14,834		14,834		327		
100 OCC MED							
100 01 VENDING ROOM	50		50				
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED	255,363	1,073,652	267,631	134,994	688,350	448,329	412,531
(WRKSHT B, PART I)							
104 UNIT COST MULTIPLIER		16.288679		4.139904		22.235233	
(WRKSHT B, PT I)	2.542975		8.967064		276.113117		24.712814
105 COST TO BE ALLOCATED	4,285	189,738	29,738	2,265	140,415	76,986	67,642
(WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER		2.878569		.069461		3.818182	
(WRKSHT B, PT II)	.042671		.996381		56.323706		4.052118
107 COST TO BE ALLOCATED							
(WRKSHT B, PART III)							
108 UNIT COST MULTIPLIER							
(WRKSHT B, PT III)							

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	NURSING ADMINISTRATION		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY
	(DIRECT SING HRS	NR(COSTED)EQUIS.	R(COSTED)EQUIS.	R(TIME)SPENT)
	14	15	16	17	
001 GENERAL SERVICE COST					
001 01 OLD CAP REL COSTS-BLD					
001 03 OLD CAP REL COSTS-BLD					
005 EMPLOYEE BENEFITS					
006 ADMINISTRATIVE & GENE					
008 OPERATION OF PLANT					
008 01 OPERATION OF PLANT-HO					
008 03 OPERATION OF PLANT-TL					
009 LAUNDRY & LINEN SERVI					
010 HOUSEKEEPING					
011 DIETARY					
012 CAFETERIA					
014 NURSING ADMINISTRATIO	177,517				
015 CENTRAL SERVICES & SU		1,193,340			
016 PHARMACY		12,895	100		
017 MEDICAL RECORDS & LIB		2,182		64,948	
025 INPAT ROUTINE SRVC CN					
025 ADULTS & PEDIATRICS	66,460	76,433		12,240	
026 INTENSIVE CARE UNIT	7,530	10,111		103	
033 NURSERY	3,211	9,637		522	
037 ANCILLARY SRVC COST C					
037 OPERATING ROOM	26,833	248,609		4,887	
039 DELIVERY ROOM & LABOR	4,200	12,211		661	
041 RADIOLOGY-DIAGNOSTIC		13,776		23,160	
042 RADIOLOGY-THERAPEUTIC		2,463			
043 RADIOISOTOPE		4,691			
044 LABORATORY		514,349		4,117	
050 PHYSICAL THERAPY		8,583		690	
051 OCCUPATIONAL THERAPY	1,698	1,191			
052 SPEECH PATHOLOGY		40			
053 ELECTROCARDIOLOGY	2,382	8,858			
055 30 IMPL. DEV. CHARGED TO					
056 DRUGS CHARGED TO PATI			100		
059 CAT SCAN		17,144			
059 01 ONCOLOGY	4,718	9,729		10	
059 02 CARDIOPULMONARY	18,280	34,396		644	
060 OUTPAT SERVICE COST C					
060 CLINIC		4,087		666	
061 EMERGENCY	37,736	117,552		17,248	
062 OBSERVATION BEDS (NON					
062 01 OBSERVATION BEDS (DIS		5,375			
066 OTHER REIMBURS COST C					
066 DURABLE MEDICAL EQUIP	4,469	37,796			
071 HOME HEALTH AGENCY		8,831			
095 SPEC PURPOSE COST CEN					
095 SUBTOTALS	177,517	1,160,939	100	64,948	
098 NONREIMBURS COST CENT					
098 PHYSICIANS' PRIVATE O					
098 01 DR. WHITT		32,401			
098 02 TLMOB					
100 OCC MED					
100 01 VENDING ROOM					
101 CROSS FOOT ADJUSTMENT					
102 NEGATIVE COST CENTER					
103 COST TO BE ALLOCATED	838,915	195,068	2,510,168	381,504	
(PER WRKSHT B, PART					
104 UNIT COST MULTIPLIER		.163464		5.873992	
(WRKSHT B, PT I)	4.725829		25,101.680000		
105 COST TO BE ALLOCATED	21,978	74,199	134,975	49,405	
(PER WRKSHT B, PART					
106 UNIT COST MULTIPLIER		.062178		.760685	
(WRKSHT B, PT II)	.123808		1,349.750000		
107 COST TO BE ALLOCATED					
(PER WRKSHT B, PART					
108 UNIT COST MULTIPLIER					
(WRKSHT B, PT III)					

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO:
I 15-1312
II PERIOD:
I FROM 1/ 1/2010
I TO 12/31/2010I PREPARED 5/20/2011
I WORKSHEET C
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	4,188,164		4,188,164		
26	INTENSIVE CARE UNIT	520,069		520,069		
33	NURSERY	203,209		203,209		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	2,538,261		2,538,261		
39	DELIVERY ROOM & LABOR ROO	275,642		275,642		
41	RADIOLOGY-DIAGNOSTIC	2,550,380		2,550,380		
42	RADIOLOGY-THERAPEUTIC	251,341		251,341		
43	RADIOISOTOPE	615,451		615,451		
44	LABORATORY	2,425,395		2,425,395		
50	PHYSICAL THERAPY	698,975		698,975		
51	OCCUPATIONAL THERAPY	116,235		116,235		
52	SPEECH PATHOLOGY	116,463		116,463		
53	ELECTROCARDIOLOGY	143,519		143,519		
55	30 IMPL. DEV. CHARGED TO PAT	7,683		7,683		
56	DRUGS CHARGED TO PATIENTS	2,510,168		2,510,168		
59	01 CAT SCAN	587,009		587,009		
59	01 ONCOLOGY	329,532		329,532		
59	02 CARDIOPULMONARY	790,369		790,369		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	167,513		167,513		
61	EMERGENCY	3,229,792		3,229,792		
62	OBSERVATION BEDS (NON-DIS					
62	01 OBSERVATION BEDS (DISTINC	530,634		530,634		
	OTHER REIMBURS COST CNTRS					
66	DURABLE MEDICAL EQUIP-REN	286,859		286,859		
101	SUBTOTAL	23,082,663		23,082,663		
102	LESS OBSERVATION BEDS					
103	TOTAL	23,082,663		23,082,663		

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	2,975,161		2,975,161			
26	INTENSIVE CARE UNIT	193,452		193,452			
33	NURSERY	230,235		230,235			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	768,355	3,326,069	4,094,424	.619931	.619931	
39	DELIVERY ROOM & LABOR ROO	291,731		291,731	.944850	.944850	
41	RADIOLOGY-DIAGNOSTIC	332,800	4,932,189	5,264,989	.484404	.484404	
42	RADIOLOGY-THERAPEUTIC	34,285	337,710	371,995	.675657	.675657	
43	RADIOISOTOPE	215,657	1,719,558	1,935,215	.318027	.318027	
44	LABORATORY	1,110,932	6,006,474	7,117,406	.340770	.340770	
50	PHYSICAL THERAPY	289,470	837,338	1,126,808	.620314	.620314	
51	OCCUPATIONAL THERAPY	85,687	96,281	181,968	.638766	.638766	
52	SPEECH PATHOLOGY	13,874	85,685	99,559	1.169789	1.169789	
53	ELECTROCARDIOLOGY	65,144	1,102,435	1,167,579	.122920	.122920	
55	30 IMPL. DEV. CHARGED TO PAT		16,966	16,966	.452847	.452847	
56	DRUGS CHARGED TO PATIENTS	1,703,443	5,580,487	7,283,930	.344617	.344617	
59	CAT SCAN	304,130	8,764,997	9,069,127	.064726	.064726	
59	01 ONCOLOGY	564	366,793	367,357	.897035	.897035	
59	02 CARDIOPULMONARY	942,098	367,107	1,309,205	.603701	.603701	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	416	39,022	39,438	4.247502	4.247502	
61	EMERGENCY	42,072	6,243,020	6,285,092	.513881	.513881	
62	OBSERVATION BEDS (NON-DIS						
62	01 OBSERVATION BEDS (DISTINC		958,331	958,331	.553706	.553706	
	OTHER REIMBURS COST CNTRS						
66	DURABLE MEDICAL EQUIP-REN		368,747	368,747	.777929	.777929	
101	SUBTOTAL	9,599,506	41,149,209	50,748,715			
102	LESS OBSERVATION BEDS						
103	TOTAL	9,599,506	41,149,209	50,748,715			

COMPUTATION OF RATIO OF COSTS TO CHARGES
 SPECIAL TITLE XIX WORKSHEET

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	4,188,164		4,188,164		
26	INTENSIVE CARE UNIT	520,069		520,069		
33	NURSERY	203,209		203,209		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	2,538,261		2,538,261		
39	DELIVERY ROOM & LABOR ROO	275,642		275,642		
41	RADIOLOGY-DIAGNOSTIC	2,550,380		2,550,380		
42	RADIOLOGY-THERAPEUTIC	251,341		251,341		
43	RADIOISOTOPE	615,451		615,451		
44	LABORATORY	2,425,395		2,425,395		
50	PHYSICAL THERAPY	698,975		698,975		
51	OCCUPATIONAL THERAPY	116,235		116,235		
52	SPEECH PATHOLOGY	116,463		116,463		
53	ELECTROCARDIOLOGY	143,519		143,519		
55	30 IMPL. DEV. CHARGED TO PAT	7,683		7,683		
56	DRUGS CHARGED TO PATIENTS	2,510,168		2,510,168		
59	01 CAT SCAN	587,009		587,009		
59	01 ONCOLOGY	329,532		329,532		
59	02 CARDIOPULMONARY	790,369		790,369		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	167,513		167,513		
61	EMERGENCY	3,229,792		3,229,792		
62	OBSERVATION BEDS (NON-DIS					
62	01 OBSERVATION BEDS (DISTINC	530,634		530,634		
	OTHER REIMBURS COST CNTRS					
66	DURABLE MEDICAL EQUIP-REN	286,859		286,859		
101	SUBTOTAL	23,082,663		23,082,663		
102	LESS OBSERVATION BEDS					
103	TOTAL	23,082,663		23,082,663		

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
I 15-1312 I FROM 1/ 1/2010 I WORKSHEET C
I I TO 12/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	2,975,161		2,975,161			
26	INTENSIVE CARE UNIT	193,452		193,452			
33	NURSERY	230,235		230,235			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	768,355	3,326,069	4,094,424	.619931	.619931	
39	DELIVERY ROOM & LABOR ROO	291,731		291,731	.944850	.944850	
41	RADIOLOGY-DIAGNOSTIC	332,800	4,932,189	5,264,989	.484404	.484404	
42	RADIOLOGY-THERAPEUTIC	34,285	337,710	371,995	.675657	.675657	
43	RADIOISOTOPE	215,657	1,719,558	1,935,215	.318027	.318027	
44	LABORATORY	1,110,932	6,006,474	7,117,406	.340770	.340770	
50	PHYSICAL THERAPY	289,470	837,338	1,126,808	.620314	.620314	
51	OCCUPATIONAL THERAPY	85,687	96,281	181,968	.638766	.638766	
52	SPEECH PATHOLOGY	13,874	85,685	99,559	1.169789	1.169789	
53	ELECTROCARDIOLOGY	65,144	1,102,435	1,167,579	.122920	.122920	
55	30 IMPL. DEV. CHARGED TO PAT		16,966	16,966	.452847	.452847	
56	DRUGS CHARGED TO PATIENTS	1,703,443	5,580,487	7,283,930	.344617	.344617	
59	CAT SCAN	304,130	8,764,997	9,069,127	.064726	.064726	
59	01 ONCOLOGY	564	366,793	367,357	.897035	.897035	
59	02 CARDIOPULMONARY	942,098	367,107	1,309,205	.603701	.603701	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	416	39,022	39,438	4.247502	4.247502	
61	EMERGENCY	42,072	6,243,020	6,285,092	.513881	.513881	
62	OBSERVATION BEDS (NON-DIS						
62	01 OBSERVATION BEDS (DISTINC		958,331	958,331	.553706	.553706	
	OTHER REIMBURS COST CNTRS						
66	DURABLE MEDICAL EQUIP-REN		368,747	368,747	.777929	.777929	
101	SUBTOTAL	9,599,506	41,149,209	50,748,715			
102	LESS OBSERVATION BEDS						
103	TOTAL	9,599,506	41,149,209	50,748,715			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	2,538,261	618,636	1,919,625			2,538,261
39	DELIVERY ROOM & LABOR ROO	275,642	44,932	230,710			275,642
41	RADIOLOGY-DIAGNOSTIC	2,550,380	408,573	2,141,807			2,550,380
42	RADIOLOGY-THERAPEUTIC	251,341	25,108	226,233			251,341
43	RADIOISOTOPE	615,451	29,322	586,129			615,451
44	LABORATORY	2,425,395	225,807	2,199,588			2,425,395
50	PHYSICAL THERAPY	698,975	146,531	552,444			698,975
51	OCCUPATIONAL THERAPY	116,235	2,395	113,840			116,235
52	SPEECH PATHOLOGY	116,463	2,306	114,157			116,463
53	ELECTROCARDIOLOGY	143,519	24,386	119,133			143,519
55	30 IMPL. DEV. CHARGED TO PAT	7,683	129	7,554			7,683
56	DRUGS CHARGED TO PATIENTS	2,510,168	134,975	2,375,193			2,510,168
59	CAT SCAN	587,009	36,289	550,720			587,009
59	01 ONCOLOGY	329,532	100,029	229,503			329,532
59	02 CARDIOPULMONARY	790,369	102,054	688,315			790,369
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	167,513	9,896	157,617			167,513
61	EMERGENCY	3,229,792	496,385	2,733,407			3,229,792
62	OBSERVATION BEDS (NON-DIS						
62	01 OBSERVATION BEDS (DISTINC	530,634	202,447	328,187			530,634
	OTHER REIMBURS COST CNTRS						
66	DURABLE MEDICAL EQUIP-REN	286,859	52,643	234,216			286,859
101	SUBTOTAL	18,171,221	2,662,843	15,508,378			18,171,221
102	LESS OBSERVATION BEDS						
103	TOTAL	18,171,221	2,662,843	15,508,378			18,171,221

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	4,094,424	.619931	.619931
39	DELIVERY ROOM & LABOR ROO	291,731	.944850	.944850
41	RADIOLOGY-DIAGNOSTIC	5,264,989	.484404	.484404
42	RADIOLOGY-THERAPEUTIC	371,995	.675657	.675657
43	RADIOISOTOPE	1,935,215	.318027	.318027
44	LABORATORY	7,117,406	.340770	.340770
50	PHYSICAL THERAPY	1,126,808	.620314	.620314
51	OCCUPATIONAL THERAPY	181,968	.638766	.638766
52	SPEECH PATHOLOGY	99,559	1.169789	1.169789
53	ELECTROCARDIOLOGY	1,167,579	.122920	.122920
55	30 IMPL. DEV. CHARGED TO PAT	16,966	.452847	.452847
56	DRUGS CHARGED TO PATIENTS	7,283,930	.344617	.344617
59	CAT SCAN	9,069,127	.064726	.064726
59	01 ONCOLOGY	367,357	.897035	.897035
59	02 CARDIOPULMONARY	1,309,205	.603701	.603701
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	39,438	4.247502	4.247502
61	EMERGENCY	6,285,092	.513881	.513881
62	OBSERVATION BEDS (NON-DIS			
62	01 OBSERVATION BEDS (DISTINC	958,331	.553706	.553706
	OTHER REIMBURS COST CNTRS			
66	DURABLE MEDICAL EQUIP-REN	368,747	.777929	.777929
101	SUBTOTAL	47,349,867		
102	LESS OBSERVATION BEDS			
103	TOTAL	47,349,867		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	2,538,261	618,636	1,919,625			2,538,261
39	DELIVERY ROOM & LABOR ROO	275,642	44,932	230,710			275,642
41	RADIOLOGY-DIAGNOSTIC	2,550,380	408,573	2,141,807			2,550,380
42	RADIOLOGY-THERAPEUTIC	251,341	25,108	226,233			251,341
43	RADIOISOTOPE	615,451	29,322	586,129			615,451
44	LABORATORY	2,425,395	225,807	2,199,588			2,425,395
50	PHYSICAL THERAPY	698,975	146,531	552,444			698,975
51	OCCUPATIONAL THERAPY	116,235	2,395	113,840			116,235
52	SPEECH PATHOLOGY	116,463	2,306	114,157			116,463
53	ELECTROCARDIOLOGY	143,519	24,386	119,133			143,519
55	30 IMPL. DEV. CHARGED TO PAT	7,683	129	7,554			7,683
56	DRUGS CHARGED TO PATIENTS	2,510,168	134,975	2,375,193			2,510,168
59	CAT SCAN	587,009	36,289	550,720			587,009
59	01 ONCOLOGY	329,532	100,029	229,503			329,532
59	02 CARDIOPULMONARY	790,369	102,054	688,315			790,369
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	167,513	9,896	157,617			167,513
61	EMERGENCY	3,229,792	496,385	2,733,407			3,229,792
62	OBSERVATION BEDS (NON-DIS						
62	01 OBSERVATION BEDS (DISTINC	530,634	202,447	328,187			530,634
	OTHER REIMBURS COST CNTRS						
66	DURABLE MEDICAL EQUIP-REN	286,859	52,643	234,216			286,859
101	SUBTOTAL	18,171,221	2,662,843	15,508,378			18,171,221
102	LESS OBSERVATION BEDS						
103	TOTAL	18,171,221	2,662,843	15,508,378			18,171,221

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
	OPERATING ROOM	4,094,424	.619931	.619931
39	DELIVERY ROOM & LABOR ROO	291,731	.944850	.944850
41	RADIOLOGY-DIAGNOSTIC	5,264,989	.484404	.484404
42	RADIOLOGY-THERAPEUTIC	371,995	.675657	.675657
43	RADIOISOTOPE	1,935,215	.318027	.318027
44	LABORATORY	7,117,406	.340770	.340770
50	PHYSICAL THERAPY	1,126,808	.620314	.620314
51	OCCUPATIONAL THERAPY	181,968	.638766	.638766
52	SPEECH PATHOLOGY	99,559	1.169789	1.169789
53	ELECTROCARDIOLOGY	1,167,579	.122920	.122920
55	30 IMPL. DEV. CHARGED TO PAT	16,966	.452847	.452847
56	DRUGS CHARGED TO PATIENTS	7,283,930	.344617	.344617
59	CAT SCAN	9,069,127	.064726	.064726
59	01 ONCOLOGY	367,357	.897035	.897035
59	02 CARDIOPULMONARY	1,309,205	.603701	.603701
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	39,438	4.247502	4.247502
61	EMERGENCY	6,285,092	.513881	.513881
62	OBSERVATION BEDS (NON-DIS			
62	01 OBSERVATION BEDS (DISTINC	958,331	.553706	.553706
	OTHER REIMBURS COST CNTRS			
66	DURABLE MEDICAL EQUIP-REN	368,747	.777929	.777929
101	SUBTOTAL	47,349,867		
102	LESS OBSERVATION BEDS			
103	TOTAL	47,349,867		

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	.619931		.619931		
39 DELIVERY ROOM & LABOR ROOM	.944850		.944850		
41 RADIOLOGY-DIAGNOSTIC	.484404		.484404		
42 RADIOLOGY-THERAPEUTIC	.675657		.675657		
43 RADIOISOTOPE	.318027		.318027		
44 LABORATORY	.340770		.340770		
50 PHYSICAL THERAPY	.620314		.620314		
51 OCCUPATIONAL THERAPY	.638766		.638766		
52 SPEECH PATHOLOGY	1.169789		1.169789		
53 ELECTROCARDIOLOGY	.122920		.122920		
55 30 IMPL. DEV. CHARGED TO PATIENT	.452847		.452847		
56 DRUGS CHARGED TO PATIENTS	.344617		.344617		
59 CAT SCAN	.064726		.064726		
59 01 ONCOLOGY	.897035		.897035		
59 02 CARDIOPULMONARY	.603701		.603701		
OUTPAT SERVICE COST CNTRS					
60 CLINIC	4.247502		4.247502		
61 EMERGENCY	.513881		.513881		
62 OBSERVATION BEDS (NON-DISTINCT PART)					
62 01 OBSERVATION BEDS (DISTINCT PART)	.553706		.553706		
OTHER REIMBURS COST CNTRS					
66 DURABLE MEDICAL EQUIP-RENTED	.777929		.777929		
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	4	5	6	7	8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		1,019,246			
39 DELIVERY ROOM & LABOR ROOM					
41 RADIOLOGY-DIAGNOSTIC		1,765,488			
42 RADIOLOGY-THERAPEUTIC		132,618			
43 RADIOISOTOPE		167,913			
44 LABORATORY		2,175,382			
50 PHYSICAL THERAPY		334,853			
51 OCCUPATIONAL THERAPY		32,769			
52 SPEECH PATHOLOGY		24,370			
53 ELECTROCARDIOLOGY		393,189			
55 30 IMPL. DEV. CHARGED TO PATIENT		10,000			
56 DRUGS CHARGED TO PATIENTS		2,909,373			
59 CAT SCAN		2,894,446			
59 01 ONCOLOGY		173,395			
59 02 CARDIOPULMONARY		168,529			
60 OUTPAT SERVICE COST CNTRS					
60 CLINIC		9,023			
61 EMERGENCY		1,679,346			
62 OBSERVATION BEDS (NON-DISTINCT PART)					
62 01 OBSERVATION BEDS (DISTINCT PART)		464,351			
66 OTHER REIMBURS COST CNTRS					
66 DURABLE MEDICAL EQUIP-RENTED					
101 SUBTOTAL		14,354,291			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		14,354,291			

(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	631,862		
39	DELIVERY ROOM & LABOR ROOM			
41	RADIOLOGY-DIAGNOSTIC	855,209		
42	RADIOLOGY-THERAPEUTIC	89,604		
43	RADIOISOTOPE	53,401		
44	LABORATORY	741,305		
50	PHYSICAL THERAPY	207,714		
51	OCCUPATIONAL THERAPY	20,932		
52	SPEECH PATHOLOGY	28,508		
53	ELECTROCARDIOLOGY	48,331		
55	30 IMPL. DEV. CHARGED TO PATIENT	4,528		
56	DRUGS CHARGED TO PATIENTS	1,002,619		
59	CAT SCAN	187,346		
59	01 ONCOLOGY	155,541		
59	02 CARDIOPULMONARY	101,741		
OUTPAT SERVICE COST CNTRS				
60	CLINIC	38,325		
61	EMERGENCY	862,984		
62	OBSERVATION BEDS (NON-DISTINCT PART)			
62	01 OBSERVATION BEDS (DISTINCT PART)	257,114		
OTHER REIMBURS COST CNTRS				
66	DURABLE MEDICAL EQUIP-RENTED			
101	SUBTOTAL	5,287,064		
102	CRNA CHARGES			
103	LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104	NET CHARGES	5,287,064		

(A) WORKSHEET A LINE NUMBERS

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

Health Financial Systems MCRIF32 FOR WHITE COUNTY MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(08/2000) CONTD

	I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/20/2011
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST	I	15-1312	I	FROM 1/ 1/2010	I	WORKSHEET D	
	I	COMPONENT NO:	I	TO 12/31/2010	I	PART VI	
	I	15-1312	I		I		

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1	.344617
2	PROGRAM VACCINE CHARGES		961
3	PROGRAM COSTS		331

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)	4,481
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,410
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,410
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	941
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	130
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,903
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	924
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	145.00
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	145.00
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	4,188,164
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	18,850
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	920,554
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,267,610

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,782,045
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,037,980
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.174535
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	597.65
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	3,267,610

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 958.24
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,823,531
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,823,531

	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	520,069	132	3,939.92	87	342,773
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					

48 PROGRAM INPATIENT ANCILLARY SERVICE COST 1,079,639
 49 TOTAL PROGRAM INPATIENT COSTS 3,245,943

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 885,414
 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 885,414
 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	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	958.24
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				

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)	4,481
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,410
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	3,410
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)	941
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)	130
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	497
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)	496
16	NURSERY DAYS (TITLE V OR XIX ONLY)	356

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	4,188,164
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)	905,788
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,282,376

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,782,045
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,037,980
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.179843
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	597.65
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	3,282,376

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 962.58
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 478,402
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 478,402

	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	203,209	496	409.70	356	145,853
43 INTENSIVE CARE UNIT	520,069	132	3,939.92	5	19,700
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					

48 PROGRAM INPATIENT ANCILLARY SERVICE COST 1 399,988
 49 TOTAL PROGRAM INPATIENT COSTS 1,043,943

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)
 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	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	962.57
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

TITLE XVIII, PART A HOSPITAL OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		1,219,276	
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS		99,431	
37	OPERATING ROOM	.619931	192,851	119,554
39	DELIVERY ROOM & LABOR ROOM	.944850		
41	RADIOLOGY-DIAGNOSTIC	.484404	271,616	131,572
42	RADIOLOGY-THERAPEUTIC	.675657	16,013	10,819
43	RADIOISOTOPE	.318027	29,283	9,313
44	LABORATORY	.340770	505,005	172,091
50	PHYSICAL THERAPY	.620314	90,677	56,248
51	OCCUPATIONAL THERAPY	.638766	26,516	16,938
52	SPEECH PATHOLOGY	1.169789	5,827	6,816
53	ELECTROCARDIOLOGY	.122920	41,119	5,054
55	30 IMPL. DEV. CHARGED TO PATIENT	.452847		
56	DRUGS CHARGED TO PATIENTS	.344617	718,249	247,521
59	CAT SCAN	.064726	199,866	12,937
59	01 ONCOLOGY	.897035	279	250
59	02 CARDIOPULMONARY	.603701	476,581	287,712
60	OUTPAT SERVICE COST CNTRS CLINIC	4.247502	132	561
61	EMERGENCY	.513881	4,385	2,253
62	OBSERVATION BEDS (NON-DISTINCT PART)			
62	01 OBSERVATION BEDS (DISTINCT PART)	.553706		
66	OTHER REIMBURS COST CNTRS DURABLE MEDICAL EQUIP-RENTED	.777929		
101	TOTAL		2,578,399	1,079,639
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		2,578,399	

TITLE XVIII, PART A

SWING BED SNF

OTHER

WKST A	COST CENTER DESCRIPTION	RATIO COST	INPATIENT	INPATIENT
LINE NO.		TO CHARGES	CHARGES	COST
		1	2	3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.619931	31,143	19,307
39	DELIVERY ROOM & LABOR ROOM	.944850		
41	RADIOLOGY-DIAGNOSTIC	.484404	20,523	9,941
42	RADIOLOGY-THERAPEUTIC	.675657	5,667	3,829
43	RADIOISOTOPE	.318027	1,655	526
44	LABORATORY	.340770	89,357	30,450
50	PHYSICAL THERAPY	.620314	141,888	88,015
51	OCCUPATIONAL THERAPY	.638766	40,460	25,844
52	SPEECH PATHOLOGY	1.169789	4,911	5,745
53	ELECTROCARDIOLOGY	.122920	2,894	356
55	30 IMPL. DEV. CHARGED TO PATIENT	.452847		
56	DRUGS CHARGED TO PATIENTS	.344617	262,563	90,484
59	CAT SCAN	.064726	7,737	501
59	01 ONCOLOGY	.897035	103	92
59	02 CARDIOPULMONARY	.603701	204,633	123,537
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	4.247502	5	21
61	EMERGENCY	.513881	17	9
62	OBSERVATION BEDS (NON-DISTINCT PART)			
62	01 OBSERVATION BEDS (DISTINCT PART)	.553706		
	OTHER REIMBURS COST CNTRS			
66	DURABLE MEDICAL EQUIP-RENTED	.777929		
101	TOTAL		813,556	398,657
102	LESS PBP CLINIC LABORATORY SERVICES -			
	PROGRAM ONLY CHARGES			
103	NET CHARGES		813,556	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

TITLE XIX

HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES	INPATIENT CHARGES	INPATIENT COST
		1	2	3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		499,361	
26	INTENSIVE CARE UNIT		4,207	
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.619931	310,424	192,441
39	DELIVERY ROOM & LABOR ROOM	.944850		
41	RADIOLOGY-DIAGNOSTIC	.484404	40,256	19,500
42	RADIOLOGY-THERAPEUTIC	.675657	4,233	2,860
43	RADIOISOTOPE	.318027	13,704	4,358
44	LABORATORY	.340770	200,058	68,174
50	PHYSICAL THERAPY	.620314		
51	OCCUPATIONAL THERAPY	.638766	191	122
52	SPEECH PATHOLOGY	1.169789		
53	ELECTROCARDIOLOGY	.122920	2,733	336
55	30 IMPL. DEV. CHARGED TO PATIENT	.452847		
56	DRUGS CHARGED TO PATIENTS	.344617	219,386	75,604
59	CAT SCAN	.064726	201	13
59	01 ONCOLOGY	.897035	145	130
59	02 CARDIOPULMONARY	.603701	34,425	20,782
60	OUTPAT SERVICE COST CNTRS CLINIC	4.247502		
61	EMERGENCY	.513881	30,489	15,668
62	OBSERVATION BEDS (NON-DISTINCT PART)			
62	01 OBSERVATION BEDS (DISTINCT PART)	.553706		
66	OTHER REIMBURS COST CNTRS DURABLE MEDICAL EQUIP-RENTED	.777929		
101	TOTAL		856,245	399,988
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		856,245	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/20/2011
I	15-1312	I	FROM 1/ 1/2010	I	WORKSHEET	E
I	COMPONENT NO:	I	TO 12/31/2010	I	PART	B
I	15-1312	I		I		

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	5,287,395
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	OUTPATIENT ANCILLARY PASSTHRU COSTS FROM (W/S D,IV (COLS 9, 9.01, 9.02) LINE 101	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	5,287,395
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	5,340,269
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	CAH DEDUCTIBLES	45,765
18.01	CAH ACTUAL BILLED COINSURANCE	2,444,337
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	2,850,167
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	2,850,167
24	PRIMARY PAYER PAYMENTS	2,104
25	SUBTOTAL	2,848,063
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	521,618
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	521,618
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	354,377
28	SUBTOTAL	3,369,681
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	3,369,681
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	3,807,775
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	-438,094
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	
	TO BE COMPLETED BY CONTRACTOR	
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)	
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY	
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	
54	TOTAL (SUM OF LINES 51 AND 53)	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3,051,893		3,560,948
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	7/22/2010	21,172	7/22/2010	113,931
ADJUSTMENTS TO PROVIDER .02	12/30/2010	242	12/30/2010	1,291
ADJUSTMENTS TO PROVIDER .03	12/30/2010	58,264	12/30/2010	299,080
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50	7/22/2010	38,771	7/22/2010	121,103
ADJUSTMENTS TO PROGRAM .51	12/30/2010	9,487	12/30/2010	46,372
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		31,420		246,827
4 TOTAL INTERIM PAYMENTS		3,083,313		3,807,775
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL .99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01			
	SETTLEMENT TO PROGRAM .02	212,322		438,094
7 TOTAL MEDICARE PROGRAM LIABILITY		2,870,991		3,369,681

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
I 15-1312 I FROM 1/ 1/2010 I WORKSHEET E-1
I COMPONENT NO: I TO 12/31/2010 I
I 15-Z312 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		1,389,545		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01				
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROVIDER .49				
ADJUSTMENTS TO PROGRAM .50	7/22/2010	4,630		
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		-4,630		NONE
4 TOTAL INTERIM PAYMENTS		1,384,915		
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)		106,841		
7 TOTAL MEDICARE PROGRAM LIABILITY		1,278,074		

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/20/2011
I	15-1312	I	FROM 1/ 1/2010	I		
I	COMPONENT NO:	I	TO 12/31/2010	I	WORKSHEET	E-2
I	15-Z312	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)	894,268	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	402,644	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	924	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	1,296,912	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	1,296,912	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	1,296,912	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	18,838	
14	80% OF PART B COSTS		
15	SUBTOTAL	1,278,074	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	1,278,074	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	1,384,915	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	-106,841	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
 I 15-1312 I FROM 1/ 1/2010 I WORKSHEET E-3
 I COMPONENT NO: I TO 12/31/2010 I PART II
 I 15-1312 I I

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	3,245,943
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	3,245,943
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	3,278,402
	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	3,278,402
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	485,333
21	EXCESS REASONABLE COST	
22	SUBTOTAL	2,793,069
23	COINSURANCE	3,025
24	SUBTOTAL	2,790,044
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	80,947
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	80,947
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	56,010
26	SUBTOTAL	2,870,991
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	2,870,991
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	3,083,313
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	-212,322
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

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

	TITLE XIX	HOSPITAL	OTHER TITLE V OR TITLE XIX	TITLE XVIII SNF PPS
			1	2
	COMPUTATION OF NET COST OF COVERED SERVICE			
1	INPATIENT HOSPITAL/SNF/NF SERVICES		1,043,943	
2	MEDICAL AND OTHER SERVICES			
3	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			
4	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)			
5	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			
6	SUBTOTAL		1,043,943	
7	INPATIENT PRIMARY PAYER PAYMENTS			
8	OUTPATIENT PRIMARY PAYER PAYMENTS			
9	SUBTOTAL		1,043,943	
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
10	ROUTINE SERVICE CHARGES			
11	ANCILLARY SERVICE CHARGES		856,245	
12	INTERNS AND RESIDENTS SERVICE CHARGES			
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE			
14	TEACHING PHYSICIANS			
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION			
16	TOTAL REASONABLE CHARGES		856,245	
	CUSTOMARY CHARGES			
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			
19	RATIO OF LINE 17 TO LINE 18			
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		856,245	
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		187,698	
23	COST OF COVERED SERVICES		1,043,943	
	PROSPECTIVE PAYMENT AMOUNT			
24	OTHER THAN OUTLIER PAYMENTS			
25	OUTLIER PAYMENTS			
26	PROGRAM CAPITAL PAYMENTS			
27	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS			
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS			
30	SUBTOTAL		1,043,943	
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)			
32	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE XVIII ENTER AMOUNT FROM LINE 30		1,043,943	
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34	EXCESS OF REASONABLE COST			
35	SUBTOTAL		1,043,943	
36	COINSURANCE			
37	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19			
38	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			
38.01	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING BEFORE 10/01/05 (SEE INSTRUCTIONS)			
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)			
39	UTILIZATION REVIEW			
40	SUBTOTAL (SEE INSTRUCTIONS)		1,043,943	
41	INPATIENT ROUTINE SERVICE COST			
42	MEDICARE INPATIENT ROUTINE CHARGES			
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT OF PART A SERVICES			
45	RATIO OF LINE 43 TO 44			
46	TOTAL CUSTOMARY CHARGES			
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			
50	OTHER ADJUSTMENTS (SPECIFY)			
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			
52	SUBTOTAL		1,043,943	
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER		1,043,943	
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
57	INTERIM PAYMENTS		588,492	
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
 I 15-1312 I FROM 1/ 1/2010 I
 I I TO 12/31/2010 I WORKSHEET G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	2,799,253			
2 TEMPORARY INVESTMENTS	53,763			
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	7,049,577			
5 OTHER RECEIVABLES				
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-2,477,674			
7 INVENTORY	812,991			
8 PREPAID EXPENSES				
9 OTHER CURRENT ASSETS	3,231,050			
10 DUE FROM OTHER FUNDS				
11 TOTAL CURRENT ASSETS	11,468,960			
FIXED ASSETS				
12 LAND				
12.01 LAND IMPROVEMENTS				
13 LESS ACCUMULATED DEPRECIATION				
14 BUILDINGS	34,153,820			
14.01 LESS ACCUMULATED DEPRECIATION				
15 LEASEHOLD IMPROVEMENTS				
15.01 LESS ACCUMULATED DEPRECIATION				
16 FIXED EQUIPMENT				
16.01 LESS ACCUMULATED DEPRECIATION				
17 AUTOMOBILES AND TRUCKS				
17.01 LESS ACCUMULATED DEPRECIATION				
18 MAJOR MOVABLE EQUIPMENT				
18.01 LESS ACCUMULATED DEPRECIATION				
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE				
21 TOTAL FIXED ASSETS	34,153,820			
OTHER ASSETS				
22 INVESTMENTS	1,002,116			
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS	913,453			
26 TOTAL OTHER ASSETS	1,915,569			
27 TOTAL ASSETS	47,538,349			

BALANCE SHEET

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/20/2011
I	15-1312	I	FROM 1/ 1/2010	I		
I		I	TO 12/31/2010	I	WORKSHEET	G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	677,713			
29 SALARIES, WAGES & FEES PAYABLE	756,849			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	3,231,050			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	986,456			
36 TOTAL CURRENT LIABILITIES	5,652,068			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	30,780,050			
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES	2,861,114			
42 TOTAL LONG-TERM LIABILITIES	33,641,164			
43 TOTAL LIABILITIES	39,293,232			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	8,245,117			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	8,245,117			
52 TOTAL LIABILITIES AND FUND BALANCES	47,538,349			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		8,830,811		
2 NET INCOME (LOSS)		-585,694		
3 TOTAL		8,245,117		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADDITIONS (CREDIT ADJUSTM				
6				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL		8,245,117		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM				
14				
15				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		8,245,117		

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

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	2,801,718		2,801,718
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	2,801,718		2,801,718
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT	158,386		158,386
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	158,386		158,386
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	2,960,104		2,960,104
17 00 ANCILLARY SERVICES	6,118,848		6,118,848
18 00 OUTPATIENT SERVICES		43,062,928	43,062,928
19 00 HOME HEALTH AGENCY			
24 00			
25 00 TOTAL PATIENT REVENUES	9,078,952	43,062,928	52,141,880

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES	28,185,902		
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		28,185,902	

STATEMENT OF REVENUES AND EXPENSES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/20/2011
I	15-1312	I	FROM 1/ 1/2010	I	WORKSHEET	G-3
I		I	TO 12/31/2010	I		

DESCRIPTION

1	TOTAL PATIENT REVENUES	52,141,880
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	25,484,458
3	NET PATIENT REVENUES	26,657,422
4	LESS: TOTAL OPERATING EXPENSES	28,185,902
5	NET INCOME FROM SERVICE TO PATIENTS	-1,528,480
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	
7	INCOME FROM INVESTMENTS	90,270
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER INCOME	607,814
24.01	OTHER NONOPERATING INCOME	618,054
24.02	MISC ADJUSTMENT	23,390
25	TOTAL OTHER INCOME	1,339,528
26	TOTAL	-188,952
	OTHER EXPENSES	
27	LOSS ON SWAP	396,742
28		
29		
30	TOTAL OTHER EXPENSES	396,742
31	NET INCOME (OR LOSS) FOR THE PERIOD	-585,694

HHA 1

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPORTATION 3	CONTRACTED/ PURCHASED SVCS 4	OTHER COSTS 5	TOTAL 6
GENERAL SERVICE COST CENTERS						
1						
2						
3						
4						
5	105,911				129,932	235,843
HHA REIMBURSABLE SERVICES						
6	95,604					95,604
7	89,513					89,513
8	2,041					2,041
9	7,707					7,707
10						
11	86,116					86,116
12						
13						
13.20						
14						
HHA NONREIMBURSABLE SERVICES						
15						
16						
17						
18						
19						
20						
21						
22	8,732					8,732
23	9,414					9,414
23.50						
24	405,038				129,932	534,970

	RECLASSIFI- CATIONS 7	RECLASSIFIED TRIAL BALANCE 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION 10
GENERAL SERVICE COST CENTERS				
1				
2				
3				
4				
5		235,843		235,843
HHA REIMBURSABLE SERVICES				
6		95,604		95,604
7		89,513		89,513
8		2,041		2,041
9		7,707		7,707
10				
11		86,116		86,116
12				
13				
13.20				
14				
HHA NONREIMBURSABLE SERVICES				
15				
16				
17				
18				
19				
20				
21				
22		8,732		8,732
23		9,414		9,414
23.50				
24		534,970		534,970

HHA 1

	NET EXPENSES FOR COST ALLOCATION	CAP-REL COST-BLDG & FIX	CAP-REL COST-MOV EQUIP	PLANT OPER & MAINT	TRANSPORTATIO N	SUBTOTAL	ADMINISTRATIV E & GENERAL
	0	1	2	3	4	4A	5
GENERAL SERVICE COST CENTERS							
1							
2							
3							
4							
5							
	ADMINISTRATIVE & GENERAL	235,843				235,843	235,843
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	95,604				95,604	75,379
7	PHYSICAL THERAPY	89,513				89,513	70,575
8	OCCUPATIONAL THERAPY	2,041				2,041	1,609
9	SPEECH PATHOLOGY	7,707				7,707	6,076
10	MEDICAL SOCIAL SERVICES						
11	HOME HEALTH AIDE	86,116				86,116	67,897
12	SUPPLIES						
13	DRUGS						
13.20	COST ADMINISTERING DRUGS						
14	DME						
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SVCS						
16	RESPIRATORY THERAPY						
17	PRIVATE DUTY NURSING						
18	CLINIC						
19	HEALTH PROM ACTIVITIES						
20	DAY CARE PROGRAM						
21	HOME DEL MEALS PROGRAM						
22	HOMEMAKER SERVICE	8,732				8,732	6,885
23	ALL OTHERS	9,414				9,414	7,422
23.50	TELEMEDICINE						
24	TOTAL (SUM OF LINES 1-23)	534,970				534,970	

TOTAL

6

GENERAL SERVICE COST CENTERS							
1	CAP-REL COST-BLDG & FIX						
2	CAP-REL COST-MOV EQUIP						
3	PLANT OPER & MAINT						
4	TRANSPORTATION						
5	ADMINISTRATIVE & GENERAL						
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	170,983					
7	PHYSICAL THERAPY	160,088					
8	OCCUPATIONAL THERAPY	3,650					
9	SPEECH PATHOLOGY	13,783					
10	MEDICAL SOCIAL SERVICES						
11	HOME HEALTH AIDE	154,013					
12	SUPPLIES						
13	DRUGS						
13.20	COST ADMINISTERING DRUGS						
14	DME						
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SVCS						
16	RESPIRATORY THERAPY						
17	PRIVATE DUTY NURSING						
18	CLINIC						
19	HEALTH PROM ACTIVITIES						
20	DAY CARE PROGRAM						
21	HOME DEL MEALS PROGRAM						
22	HOMEMAKER SERVICE	15,617					
23	ALL OTHERS	16,836					
23.50	TELEMEDICINE						
24	TOTAL (SUM OF LINES 1-23)	534,970					

HHA 1

	CAP-REL COST-BLDG & FIX (SQUARE FEET)	CAP-REL COST-MOV EQUIP (DOLLAR VALUE)	PLANT OPER & MAINT (SQUARE FEET)	TRANSPORTATIO N (MILEAGE)	RECONCILIATIO N 5A	ADMINISTRATIV E & GENERAL (ACCUM. COST)
	1	2	3	4		5
1	GENERAL SERVICE COST CENTERS					
1	CAP-REL COST-BLDG & FIX					
2	CAP-REL COST-MOV EQUIP					
3	PLANT OPER & MAINT					
4	TRANSPORTATION					
5	ADMINISTRATIVE & GENERAL					
					-235,843	299,127
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE					
7	PHYSICAL THERAPY					
8	OCCUPATIONAL THERAPY					
9	SPEECH PATHOLOGY					
10	MEDICAL SOCIAL SERVICES					
11	HOME HEALTH AIDE					
12	SUPPLIES					
13	DRUGS					
13.20	COST ADMINISTERING DRUGS					
14	DME					
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SVCS					
16	RESPIRATORY THERAPY					
17	PRIVATE DUTY NURSING					
18	CLINIC					
19	HEALTH PROM ACTIVITIES					
20	DAY CARE PROGRAM					
21	HOME DEL MEALS PROGRAM					
22	HOMEMAKER SERVICE					
23	ALL OTHERS					
23.50	TELEMEDICINE					
24	TOTAL (SUM OF LINES 1-23)					
25					-235,843	299,127
26	UNIT COST MULTIPLIER					
						235,843
						.788438

HHA 1

HHA COST CENTER	HHA TRIAL BALANCE (1) 0	OLD CAP REL COSTS-BLDG & 1	OLD CAP REL COSTS-BLDG & 1.01	OLD CAP REL COSTS-BLDG & 1.03	EMPLOYEE BEN EFITS 5	SUBTOTAL 5A
1 ADMIN & GENERAL		1,298				
2 SKILLED NURSING CARE	170,983			22,340	78,352	101,990
3 PHYSICAL THERAPY	160,088					170,983
4 OCCUPATIONAL THERAPY	3,650					160,088
5 SPEECH PATHOLOGY	13,783					3,650
6 MEDICAL SOCIAL SERVICES						13,783
7 HOME HEALTH AIDE	154,013					
8 SUPPLIES						154,013
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE	15,617					
19 ALL OTHER	16,836					15,617
19.50 TELEMEDICINE						16,836
20 TOTAL (SUM OF 1-19) (2)	534,970	1,298		22,340	78,352	636,960
21 UNIT COST MULTIPLIER						

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

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

HHA COST CENTER	ADMINISTRATI VE & GENERAL 6	OPERATION OF PLANT 8	OPERATION OF PLANT-HOSPI 8.01	OPERATION OF PLANT-TLMAB 8.03	LAUNDRY & LI NEN SERVICE 9	HOUSEKEEPING 10
1 ADMIN & GENERAL	18,897	2,390				
2 SKILLED NURSING CARE	31,682			8,429		10,216
3 PHYSICAL THERAPY	29,662					
4 OCCUPATIONAL THERAPY	676					
5 SPEECH PATHOLOGY	2,554					
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE	28,536					
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE	2,894					
19 ALL OTHER	3,119					
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	118,020	2,390		8,429		10,216
21 UNIT COST MULTIPLIER						

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

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

HHA 1

HHA COST CENTER	DIETARY 11	CAFETERIA 12	NURSING ADMINISTRATION 14	CENTRAL SERVICES & SUPPLIES 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17
1 ADMIN & GENERAL						
2 SKILLED NURSING CARE		25,602		1,444		
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)		25,602		1,444		
21 UNIT COST MULTIPLIER						

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

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

HHA COST CENTER	SUBTOTAL 25	POST STEP DOWN ADJUST 26	SUBTOTAL 27	ALLOCATED HHA A & G 28	TOTAL HHA COSTS 29
1 ADMIN & GENERAL	168,968		168,968		
2 SKILLED NURSING CARE	202,665		202,665		
3 PHYSICAL THERAPY	189,750		189,750	54,005	256,670
4 OCCUPATIONAL THERAPY	4,326		4,326	50,563	240,313
5 SPEECH PATHOLOGY	16,337		16,337	1,153	5,479
6 MEDICAL SOCIAL SERVICES				4,353	20,690
7 HOME HEALTH AIDE	182,549		182,549		
8 SUPPLIES				48,644	231,193
9 DRUGS					
9.20 COST ADMINISTERING DRUGS					
10 DME					
11 HOME DIALYSIS AIDE SVCS					
12 RESPIRATORY THERAPY					
13 PRIVATE DUTY NURSING					
14 CLINIC					
15 HEALTH PROM ACTIVITIES					
16 DAY CARE PROGRAM					
17 HOME DEL MEALS PROGRAM					
18 HOMEMAKER SERVICE	18,511		18,511	4,933	23,444
19 ALL OTHER	19,955		19,955	5,317	25,272
19.50 TELEMEDICINE					
20 TOTAL (SUM OF 1-19) (2)	803,061		803,061	168,968	803,061
21 UNIT COST MULTIPLIER				0.266472	

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

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

HHA 1

HHA COST CENTER	OLD CAP REL COSTS-BLDG & (SQUARE FEET)	OLD CAP REL COSTS-BLDG & (SQUARE FEET)	OLD CAP REL COSTS-BLDG & (SQUARE FEET)	EMPLOYEE BEN EFITS (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)
1 ADMIN & GENERAL	940	1.01	1.03	5	6A	6
2 SKILLED NURSING CARE			940	405,038		101,990
3 PHYSICAL THERAPY						170,983
4 OCCUPATIONAL THERAPY						160,088
5 SPEECH PATHOLOGY						3,650
6 MEDICAL SOCIAL SERVICES						13,783
7 HOME HEALTH AIDE						
8 SUPPLIES						154,013
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						15,617
19.50 TELEMEDICINE						16,836
20 TOTAL (SUM OF 1-19)	940		940	405,038		636,960
21 COST TO BE ALLOCATED	1,298		22,340	78,352		118,020
22 UNIT COST MULTIPLIER	1.380851		23.765957	0.193444		0.185286

HHA COST CENTER	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-HOSPITAL (SQUARE FEET)	OPERATION OF PLANT-TLMAB (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)
1 ADMIN & GENERAL	940	8.01	8.03	9	10	11
2 SKILLED NURSING CARE			940		37	
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)	940		940		37	
21 COST TO BE ALLOCATED	2,390		8,429		10,216	
22 UNIT COST MULTIPLIER	2.542553		8.967021		276.108108	

HHA 1

HHA COST CENTER	CAFETERIA (FTES 12	NURSING ADMINISTRATION (DIRECT SING HRS 14	CENTRAL SERVICES & SUPPLIES (COSTED EQUIS. 15	PHARMACY (COSTED EQUIS. 16	MEDICAL RECORDS & LIBRARY (TIME SPENT 17
1 ADMIN & GENERAL	1,036		8,831		
2 SKILLED NURSING CARE					
3 PHYSICAL THERAPY					
4 OCCUPATIONAL THERAPY					
5 SPEECH PATHOLOGY					
6 MEDICAL SOCIAL SERVICES					
7 HOME HEALTH AIDE					
8 SUPPLIES					
9 DRUGS					
9.20 COST ADMINISTERING DRUGS					
10 DME					
11 HOME DIALYSIS AIDE SVCS					
12 RESPIRATORY THERAPY					
13 PRIVATE DUTY NURSING					
14 CLINIC					
15 HEALTH PROM ACTIVITIES					
16 DAY CARE PROGRAM					
17 HOME DEL MEALS PROGRAM					
18 HOMEMAKER SERVICE					
19 ALL OTHER					
19.50 TELEMEDICINE					
20 TOTAL (SUM OF 1-19)	1,036		8,831		
21 COST TO BE ALLOCATED	25,602		1,444		
22 UNIT COST MULTIPLIER	24.712355		0.163515		

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

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

COST PER VISIT COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	PROGRAM VISITS
PATIENT SERVICES							
1 SKILLED NURSING	2	256,670	2	256,670	2,051	125.14	6
2 PHYSICAL THERAPY	3	240,313		240,313	1,999	120.22	720
3 OCCUPATIONAL THERAPY	4	5,479		5,479	34	161.15	855
4 SPEECH PATHOLOGY	5	20,690		20,690	86	240.58	12
5 MEDICAL SOCIAL SERVICES	6						28
6 HOME HEALTH AIDE SERVICE	7	231,193		231,193	3,484	66.36	356
7 TOTAL		754,345		754,345	7,654		1,971

	PROGRAM VISITS		COST OF SERVICES		TOTAL PROGRAM COST
	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	
1 SKILLED NURSING	7	8	9	10	12
2 PHYSICAL THERAPY		560	90,101	70,078	160,179
3 OCCUPATIONAL THERAPY		481	102,788	57,826	160,614
4 SPEECH PATHOLOGY		8	1,934	1,289	3,223
5 MEDICAL SOCIAL SERVICES		47	6,736	11,307	18,043
6 HOME HEALTH AIDE SERVICES		372	23,624	24,686	48,310
7 TOTAL		1,468	225,183	165,186	390,369

LIMITATION COST COMPUTATION

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

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

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
 I 15-1312 I FROM 1/ 1/2010 I WORKSHEET H-6
 I HHA NO: I TO 12/31/2010 I PARTS I II & III
 I 15-7514 I HHA 1

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

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

SUPPLIES AND EQUIPMENT COST COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I) 1	SHARED ANCILLARY COSTS (FROM PART II) 2	TOTAL HHA COSTS 3	TOTAL CHARGES 4	RATIO 5	PROGRAM COVERED CHARGES PART A 6
15 COST OF MEDICAL SUPPLIES	8.00						
16 COST OF DRUGS	9.00				1,280		514
16.20 COST OF DRUGS	9.20						

	PROGRAM COVERED CHARGES		-----COST OF SERVICES-----		
	NOT SUBJECT TO DEDUCT & COINSUR 7	SUBJECT TO DEDUCT & COINSUR 8	PART A 9	NOT SUBJECT TO DEDUCT & COINSUR 10	SUBJECT TO DEDUCT & COINSUR 11
15 COST OF MEDICAL SUPPLIES		766			
16 COST OF DRUGS					
16.20 COST OF DRUGS					

PER BENEFICIARY COST
 LIMITATION:

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

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

	FROM WKST C PT I, COL 9	COST TO CHARGE RATIO 1	TOTAL HHA CHARGES 2	HHA SHARED ANCILLARY COSTS 3	TRANSFER TO PART I AS INDICATED 4
1 PHYSICAL THERAPY	50	.620314			COL 2, LN 2
2 OCCUPATIONAL THERAPY	51	.638766			COL 2, LN 3
3 SPEECH PATHOLOGY	52	1.169789			COL 2, LN 4
4 MEDICAL SUPPLIES CHARGED TO PATIENT	55				COL 2, LN 15
4.30 IMPL. DEV. CHARGED TO PATIENT	55.30	.452847			
5 DRUGS CHARGED TO PATIENTS	56	.344617			COL 2, LN 16

PART III - OUTPATIENT THERAPY REDUCTION COMPUTATION

	FROM PART I, COL 5 1	COST PER VISIT 2	PART B SERVICES SUBJECT TO DEDUCTIBLES AND COINSURANCE		PROGRAM COSTS		PROG VISITS ON OR AFTER 5
			PRIOR 1/1/1998 2.01	1/1/1998 TO 12/31/1998 3	PRIOR 1/1/1998 3.01	1/1/1998 TO 12/31/1998 4	
1 PHYSICAL THERAPY		120.22					
2 OCCUPATIONAL THERAPY		161.15					
3 SPEECH PATHOLOGY		240.58					
4 TOTAL (SUM OF LINES 1-3)							

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
 I 15-1312 I FROM 1/ 1/2010 I WORKSHEET H-7
 I HHA NO: I TO 12/31/2010 I PARTS I & II
 I 15-7514 I I

TITLE XVIII

HHA 1

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

PART B
 NOT SUBJECT TO
 DED & COINS
 2

PART B
 SUBJECT TO
 DED & COINS
 3

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

1

2

3

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

PART A
 SERVICES
 1

PART B
 SERVICES
 2

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

303,485

206,311

2,159

2,496

1,405

1,428

1,251

35

307,409

211,161

307,409

211,161

307,409

211,161

307,409

211,161

307,409

211,161

307,409

211,161

307,408

211,160

1

1

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO I PROVIDER NO: I PERIOD: I PREPARED 5/20/2011
 PROGRAM BENEFICIARIES I 15-1312 I FROM 1/ 1/2010 I WORKSHEET H-8
 I HHA NO: I TO 12/31/2010 I
 I 15-7514 I

TITLE XVIII HHA 1

DESCRIPTION	P A R T A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				
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.		307,408		211,160
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)		NONE		NONE
ADJUSTMENTS TO PROVIDER .01				
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL				
4 TOTAL INTERIM PAYMENTS			NONE 307,408	NONE 211,160
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				
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			NONE 1	NONE 1
7 TOTAL MEDICARE PROGRAM LIABILITY			307,409	211,161

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.