

**GREENE COUNTY GENERAL HOSPITAL
LINTON, INDIANA**

PROVIDER NOS. 15-1317, 15-Z317 AND AIM NO. 100269150

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

DECEMBER 31, 2010

GREENE COUNTY GENERAL HOSPITAL

PROVIDER NOS. 15-1317, 15-Z317 AND AIM NO. 100269150

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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs

Board of Trustees
Greene County General Hospital
Linton, Indiana

We have compiled the Hospital Statement of Reimbursable Costs (Title XVIII and XIX) of Greene County General Hospital for the year ended December 31, 2010 in the accompanying prescribed form in accordance with Statements on Standards for Accounting Review Services issued by the American Institute of Certified Public Accountants.

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

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

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

Bradley Associates

May 24, 2011

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	15-1317	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	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/27/2011 TIME 8:54

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:
GREENE COUNTY GENERAL HOSPITAL 15-1317
FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2010 AND ENDING 12/31/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
DATE: 5/27/2011 TIME 8:54

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ORJEI0bkiRobBmR9THavXvpcIp1skr
ea0U000Jtb06yofT

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OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2	3	4		
1	HOSPITAL	0	685,116	109,240	0	
3	SWING BED - SNF	0	17,669	0	0	
100	TOTAL	0	702,785	109,240	0	

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: R.R. 1 P.O. BOX:
 1.01 CITY: LINTON STATE: IN ZIP CODE: 47441-9457 COUNTY: GREENE

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N)
02.00 HOSPITAL	GREENE COUNTY GENERAL HOSPITAL	15-1317	2.01	2/ 1/2003	V XVIII XIX
04.00 SWING BED - SNF	GREENE COUNTY GENERAL HOSPITAL	15-2317		2/ 1/2003	N 0 N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2010 TO: 12/31/2010 1 2
 18 TYPE OF CONTROL 6

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
 20 SUBPROVIDER

OTHER INFORMATION

- 21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.
- 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(C)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. N
- 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
- 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 Y 15
- 21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 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.
- 22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N
- 23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N
- 23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. / / / /
- 23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY) / /
- 24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). / /

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

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

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

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

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

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

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 OCCURING 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. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)

	1	2	3	4
28.02	0	0.0000	0.0000	
28.02	0.00	0		

28.02 ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY

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

	%	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). Y

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

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

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

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

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

MISCELLANEOUS COST REPORT INFORMATION

32 IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2. N
 33 IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2 N
 34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (F)(1)(i) TEFRA? N
 35 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(F)(1)(i)? N
 35.01 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(F)(1)(i)? N
 35.02 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(F)(1)(i)? N
 35.03 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(F)(1)(i)? N
 35.04 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(F)(1)(i)? N

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL V XVIII XIX
 36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) 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). Y

40.01 NAME: FI/CONTRACTOR NAME FI/CONTRACTOR #
 40.02 STREET: P.O. BOX:
 40.03 CITY: STATE: ZIP CODE: -

41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 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 NHC MQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

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

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

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

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.

	DATE 0	Y OR N 1	LIMIT 2	Y OR N 3	FEES 4
56.01		N	0.00		0
56.02			0.00		0
56.03			0.00		0

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N

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

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

59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(C)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC). 0

MULTICAMPUS

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

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

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00

SETTLEMENT DATA

63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). Y 5/13/2011

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 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	TITLE V 3	I/P DAYS / TITLE XVIII 4	O/P VISITS / NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1 ADULTS & PEDIATRICS	20	7,300	64,008.00		2,020		157
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF					123		
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	20	7,300	64,008.00		2,143		157
6 INTENSIVE CARE UNIT	5	1,825	6,408.00		298		6
11 NURSERY							114
12 TOTAL	25	9,125	70,416.00		2,441		277
13 RPCH VISITS							
18 HOME HEALTH AGENCY							
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 ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS / TOTAL ALL PATS 6	TRIPS TOTAL OBSERVATION BEDS ADMITTED 6.01	DISCHARGES NOT ADMITTED 6.02	INTERNS & RES. FTES TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			2,630				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			123				
4 ADULTS & PED-SB NF			53				
5 TOTAL ADULTS AND PEDS			2,806				
6 INTENSIVE CARE UNIT			304				
11 NURSERY			173				
12 TOTAL			3,283				
13 RPCH VISITS							
18 HOME HEALTH AGENCY							
25 TOTAL							
26 OBSERVATION BED DAYS			582				
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	I & R FTES NET 9	FULL TIME EQUIV EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS					690	78	941
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
6 INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL		218.60			690	78	941
13 RPCH VISITS							
18 HOME HEALTH AGENCY							
25 TOTAL		218.60					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:
I 15-1317
I

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

I PREPARED 5/26/2011
I WORKSHEET A
I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		294,069	294,069	37,227	331,296
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		377,479	377,479	2,999	380,478
5	0500 EMPLOYEE BENEFITS		2,986,769	2,986,769	12,048	2,998,817
6	0600 ADMINISTRATIVE & GENERAL	1,093,274	1,813,091	2,906,365	4,059	2,910,424
8	0800 OPERATION OF PLANT	372,307	998,894	1,371,201		1,371,201
9	0900 LAUNDRY & LINEN SERVICE		122,063	122,063		122,063
10	1000 HOUSEKEEPING	295,811	68,805	364,616		364,616
11	1100 DIETARY	423,135	436,848	859,983	-753,766	106,217
12	1200 CAFETERIA				697,433	697,433
14	1400 NURSING ADMINISTRATION	519,404	49,111	568,515		568,515
15	1500 CENTRAL SERVICES & SUPPLY		1,324	1,324		1,324
16	1600 PHARMACY	629,718	180,046	809,764		809,764
17	1700 MEDICAL RECORDS & LIBRARY	193,468	50,162	243,630		243,630
18	1800 SOCIAL SERVICE	107,289		107,289		107,289
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	2,427,125	99,128	2,526,253	-25,501	2,500,752
26	2600 INTENSIVE CARE UNIT	694,318	39,808	734,126		734,126
33	3300 NURSERY	27,209	1,671	28,880		28,880
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	348,892	142,312	491,204		491,204
38	3800 RECOVERY ROOM					
39	3900 DELIVERY ROOM & LABOR ROOM		3,721	3,721	25,501	29,222
40	4000 ANESTHESIOLOGY	301,322	15,842	317,164		317,164
41	4100 RADIOLOGY-DIAGNOSTIC	830,337	767,498	1,597,835		1,597,835
42	4200 RADIOLOGY-THERAPEUTIC					
44	4400 LABORATORY	770,561	1,500,296	2,270,857		2,270,857
45	4500 PBP CLINICAL LAB SERVICES-PRGM ONLY					
48	4800 INTRAVENOUS THERAPY					
49	4900 RESPIRATORY THERAPY	476,779	34,902	511,681		511,681
50	5000 PHYSICAL THERAPY	230,321	29,043	259,364		259,364
51	5100 OCCUPATIONAL THERAPY	64,747		64,747		64,747
52	5200 SPEECH PATHOLOGY	6,274		6,274		6,274
53	5300 ELECTROCARDIOLOGY	28,187	75,740	103,927		103,927
54	5400 ELECTROENCEPHALOGRAPHY					
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		231,042	231,042	-3,905	227,137
55.30	5530 IMPL. DEV. CHARGED TO PATIENT				3,905	3,905
56	5600 DRUGS CHARGED TO PATIENTS		1,163,031	1,163,031		1,163,031
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC					
61	6100 EMERGENCY	352,965	1,129,167	1,482,132		1,482,132
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
65	6500 AMBULANCE SERVICES					
66	6600 DURABLE MEDICAL EQUIP-RENTED					
67	6700 DURABLE MEDICAL EQUIP-SOLD					
71	7100 HOME HEALTH AGENCY					
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE					
95	9500 SUBTOTALS	10,193,443	12,611,862	22,805,305	-0-	22,805,305
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800 PHYSICIANS' PRIVATE OFFICES					
100	7950 FOUNDATION/ MOBS					
101	TOTAL	10,193,443	12,611,862	22,805,305	-0-	22,805,305

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1317 I FROM 1/ 1/2010 I WORKSHEET A
I I TO 12/31/2010 I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	2,500	333,796
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-208,920	171,558
5	0500 EMPLOYEE BENEFITS		2,998,817
6	0600 ADMINISTRATIVE & GENERAL	-82,054	2,828,370
8	0800 OPERATION OF PLANT		1,371,201
9	0900 LAUNDRY & LINEN SERVICE		122,063
10	1000 HOUSEKEEPING		364,616
11	1100 DIETARY		106,217
12	1200 CAFETERIA	-239,910	457,523
14	1400 NURSING ADMINISTRATION		568,515
15	1500 CENTRAL SERVICES & SUPPLY		1,324
16	1600 PHARMACY	-380	809,384
17	1700 MEDICAL RECORDS & LIBRARY	-5,251	238,379
18	1800 SOCIAL SERVICE		107,289
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS		2,500,752
26	2600 INTENSIVE CARE UNIT		734,126
33	3300 NURSERY		28,880
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		491,204
38	3800 RECOVERY ROOM		
39	3900 DELIVERY ROOM & LABOR ROOM		29,222
40	4000 ANESTHESIOLOGY		317,164
41	4100 RADIOLOGY-DIAGNOSTIC		1,597,835
42	4200 RADIOLOGY-THERAPEUTIC		
44	4400 LABORATORY	-40,000	2,230,857
45	4500 PBP CLINICAL LAB SERVICES-PRGM ONLY		
48	4800 INTRAVENOUS THERAPY		
49	4900 RESPIRATORY THERAPY		511,681
50	5000 PHYSICAL THERAPY		259,364
51	5100 OCCUPATIONAL THERAPY		64,747
52	5200 SPEECH PATHOLOGY		6,274
53	5300 ELECTROCARDIOLOGY		103,927
54	5400 ELECTROENCEPHALOGRAPHY		
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		227,137
55.30	5530 IMPL. DEV. CHARGED TO PATIENT		3,905
56	5600 DRUGS CHARGED TO PATIENTS		1,163,031
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC		
61	6100 EMERGENCY	-818,872	663,260
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
	OTHER REIMBURS COST CNTRS		
65	6500 AMBULANCE SERVICES		
66	6600 DURABLE MEDICAL EQUIP-RENTED		
67	6700 DURABLE MEDICAL EQUIP-SOLD		
71	7100 HOME HEALTH AGENCY		
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
95	SUBTOTALS	-1,392,887	21,412,418
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800 PHYSICIANS' PRIVATE OFFICES		
100	7950 FOUNDATION/ MOBS	298,252	298,252
101	TOTAL	-1,094,635	21,710,670

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
33	NURSERY	3300	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
38	RECOVERY ROOM	3800	
39	DELIVERY ROOM & LABOR ROOM	3900	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
42	RADIOLOGY-THERAPEUTIC	4200	
44	LABORATORY	4400	
45	PBP CLINICAL LAB SERVICES-PRGM ONLY	4500	
48	INTRAVENOUS THERAPY	4800	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
54	ELECTROENCEPHALOGRAPHY	5400	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
55.30	IMPL. DEV. CHARGED TO PATIENT	5530	IMPL. DEV. CHARGED TO PATIENT
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
66	DURABLE MEDICAL EQUIP-RENTED	6600	
67	DURABLE MEDICAL EQUIP-SOLD	6700	
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
100	FOUNDATION/ MOBS	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151317	FROM 1/ 1/2010	5/26/2011
	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 INSURANCE	A	NEW CAP REL COSTS-BLDG & FIXT	3		37,227
2		NEW CAP REL COSTS-MVBLE EQUIP	4		2,999
3		EMPLOYEE BENEFITS	5		12,048
4 LABOR & DELIVERY	B	DELIVERY ROOM & LABOR ROOM	39	25,501	
5 DIETARY/CAFETERIA	C	ADMINISTRATIVE & GENERAL	6	27,717	28,616
6		CAFETERIA	12	343,156	354,277
7 IMPLANTABLE DEVICES	D	IMPL. DEV. CHARGED TO PATIENT	55.30		3,905
36 TOTAL RECLASSIFICATIONS				396,374	439,072

(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.

PROVIDER NO:

PERIOD:

PREPARED 5/26/2011

151317

FROM 1/ 1/2010

WORKSHEET A-6

TO 12/31/2010

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION	DECREASE				A-7 REF 10	
	CODE (1)	COST CENTER	LINE NO	SALARY		OTHER
	1	6	7	8	9	
1 INSURANCE	A	ADMINISTRATIVE & GENERAL	6		52,274	9
2						9
3						
4 LABOR & DELIVERY	B	ADULTS & PEDIATRICS	25	25,501		
5 DIETARY/CAFETERIA	C	DIETARY	11	370,873	382,893	
6						
7 IMPLANTABLE DEVICES	D	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		3,905	
36 TOTAL RECLASSIFICATIONS				396,374	439,072	

(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:
151317

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

PREPARED 5/26/2011
WORKSHEET A-6
NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : INSURANCE

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	37,227	ADMINISTRATIVE & GENERAL	6	52,274	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	2,999			0	
3.00	EMPLOYEE BENEFITS	5	12,048			0	
TOTAL RECLASSIFICATIONS FOR CODE A			52,274			52,274	

RECLASS CODE: B
EXPLANATION : LABOR & DELIVERY

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	DELIVERY ROOM & LABOR ROOM	39	25,501	ADULTS & PEDIATRICS	25	25,501	
TOTAL RECLASSIFICATIONS FOR CODE B			25,501			25,501	

RECLASS CODE: C
EXPLANATION : DIETARY/CAFETERIA

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ADMINISTRATIVE & GENERAL	6	56,333	DIETARY	11	753,766	
2.00	CAFETERIA	12	697,433			0	
TOTAL RECLASSIFICATIONS FOR CODE C			753,766			753,766	

RECLASS CODE: D
EXPLANATION : IMPLANTABLE DEVICES

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	IMPL. DEV. CHARGED TO PATIENT	55.30	3,905	MEDICAL SUPPLIES CHARGED TO PA	55	3,905	
TOTAL RECLASSIFICATIONS FOR CODE D			3,905			3,905	

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING	PURCHASES	ACQUISITIONS	TOTAL	DISPOSALS	ENDING	FULLY
		BALANCES		DONATION		AND		BALANCE
		1	2	3	4	5	6	7
1	LAND	759,198					759,198	
2	LAND IMPROVEMENTS	440,077	37,200		37,200		477,277	
3	BUILDINGS & FIXTURE	7,347,649				91,678	7,255,971	
4	BUILDING IMPROVEMEN	204,672				204,672		
5	FIXED EQUIPMENT	843,658	116,453		116,453		960,111	
6	MOVABLE EQUIPMENT	3,481,136				157,296	3,323,840	
7	SUBTOTAL	13,076,390	153,653		153,653	453,646	12,776,397	
8	RECONCILING ITEMS							
9	TOTAL	13,076,390	153,653		153,653	453,646	12,776,397	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL
		GROSS ASSETS 1	CAPITIALIZED LEASES 2	GROSS ASSETS FOR RATIO 3	INSURANCE 5	TAXES 6	OTHER CAPITAL RELATED COSTS 7	
3	NEW CAP REL COSTS-BL	9,452,557		9,452,557				8
4	NEW CAP REL COSTS-MV	3,323,840		3,323,840				
5	TOTAL	12,776,397		12,776,397				

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	333,796						15
4	NEW CAP REL COSTS-MV	171,558						333,796
5	TOTAL	505,354						171,558

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	294,069						15
4	NEW CAP REL COSTS-MV	377,479						294,069
5	TOTAL	671,548						377,479

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

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST. A-7 REF. 5
			COST CENTER	LINE NO	
1			**COST CENTER DELETED**	1	
2			**COST CENTER DELETED**	2	
3			NEW CAP REL COSTS-BLDG &	3	
4			NEW CAP REL COSTS-MVBLE E	4	
5					
6					
7					
8	B	2,500	NEW CAP REL COSTS-BLDG &	3	9
9	A	-8,519	ADMINISTRATIVE & GENERAL	6	
10					
11					
12	A-8-2	-858,872			
13					
14	A-8-1	298,252			
15					
16	B	-239,910	CAFETERIA	12	
17					
18					
19					
20	B	-5,251	MEDICAL RECORDS & LIBRARY	17	
21					
22	B	-1,700	ADMINISTRATIVE & GENERAL	6	
23					
24					
25	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	A-8-3				
28			**COST CENTER DELETED**	89	
29			**COST CENTER DELETED**	1	
30			**COST CENTER DELETED**	2	
31			NEW CAP REL COSTS-BLDG &	3	
32			NEW CAP REL COSTS-MVBLE E	4	
33			**COST CENTER DELETED**	20	
34					
35	A-8-4		OCCUPATIONAL THERAPY	51	
36	A-8-4		SPEECH PATHOLOGY	52	
37	B	-380	PHARMACY	16	
38	B	-983	ADMINISTRATIVE & GENERAL	6	
39	B	-638	ADMINISTRATIVE & GENERAL	6	
40	A	-59,958	ADMINISTRATIVE & GENERAL	6	
41	A	-208,920	NEW CAP REL COSTS-MVBLE E	4	9
42	A	-450	ADMINISTRATIVE & GENERAL	6	
43	A	-806	ADMINISTRATIVE & GENERAL	6	
44	A	-9,000	ADMINISTRATIVE & GENERAL	6	
45					
46					
47					
48					
49					
50		-1,094,635			

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

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	100	FOUNDATION/ MOBS	FOUNDATION/MOB- NET LOSS	298,252		298,252
2						
3						
4						
5	TOTALS			298,252		298,252

* THE AMOUNTS ON LINES 1-4 AND SUBSCRIPTS AS APPROPRIATE ARE TRANSFERRED IN DETAIL TO WORKSHEET A, COLUMN 6, LINES AS APPROPRIATE. POSITIVE AMOUNTS INCREASE COST AND NEGATIVE AMOUNTS DECREASE COST. FOR RELATED ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:
 THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THIS INFORMATION IS USED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
1	C	100.00	GCGH FOUNDATION	0.00	
2		0.00		0.00	
3		0.00		0.00	
4		0.00		0.00	
5		0.00		0.00	

(1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO:
I 15-1317
I

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

I PREPARED 5/26/2011
I WORKSHEET A-8-2
I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF COL 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COL 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
10	11	12	13	14	15	16	17	18
1	61 ER							818,872
2	44 LAB							40,000
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL							858,872

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1317 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				
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	3	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	9	HOURS OF	SERVICE	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	11	HOURS		ENTERED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED	REQUIS.	ENTERED
16	PHARMACY	15	COSTED	REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME	SPENT	ENTERED
18	SOCIAL SERVICE	17	TIME	SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
	0	3	4	5	5a.00	6	8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	333,796	333,796					
005 NEW CAP REL COSTS-MVBLE E	171,558		171,558				
006 EMPLOYEE BENEFITS	2,998,817			2,998,817			
008 ADMINISTRATIVE & GENERAL OPERATION OF PLANT	2,828,370	50,738	26,077	297,779	3,202,964	3,202,964	
009 LAUNDRY & LINEN SERVICE	1,371,201	32,134	16,515	98,899	1,518,749	262,836	1,781,585
010 HOUSEKEEPING	122,063	4,328	2,225		128,616	22,258	30,731
011 DIETARY	364,616	3,187	1,638	78,579	448,020	77,535	22,629
012 CAFETERIA	106,217	19,647	10,098	13,883	149,845	25,932	139,498
014 NURSING ADMINISTRATION	457,523	11,988	6,161	91,156	566,828	98,096	85,115
015 CENTRAL SERVICES & SUPPLY	568,515	3,004	1,544	137,974	711,037	123,053	21,325
016 PHARMACY	1,324	4,545	2,336		8,205	1,420	32,267
017 MEDICAL RECORDS & LIBRARY	809,384	5,194	2,669	167,278	984,525	170,383	36,877
018 SOCIAL SERVICE	238,379	6,610	3,397	51,393	299,779	51,880	46,934
025 INPAT ROUTINE SRVC CNTRS	107,289	1,620	833	28,500	138,242	23,924	11,501
026 ADULTS & PEDIATRICS	2,500,752	59,458	30,562	637,969	3,228,741	558,770	422,174
033 INTENSIVE CARE UNIT	734,126	17,175	8,827	184,438	944,566	163,468	121,945
037 NURSERY	28,880	3,345	1,719	7,228	41,172	7,125	23,746
038 ANCILLARY SRVC COST CNTRS							
039 OPERATING ROOM	491,204	28,435	14,614	92,679	626,932	108,497	201,891
040 RECOVERY ROOM							
041 DELIVERY ROOM & LABOR ROO	29,222	13,667	7,024	6,774	56,687	9,810	97,034
042 ANESTHESIOLOGY	317,164			80,043	397,207	68,741	
044 RADIOLOGY-DIAGNOSTIC	1,597,835	20,172	10,368	220,570	1,848,945	319,980	143,223
045 RADIOLOGY-THERAPEUTIC							
048 LABORATORY	2,230,857	12,670	6,512	204,691	2,454,730	424,818	89,957
049 PBP CLINICAL LAB SERVICES							
050 INTRAVENOUS THERAPY							
051 RESPIRATORY THERAPY	511,681	2,997	1,540	126,651	642,869	111,256	21,279
052 PHYSICAL THERAPY	259,364	5,384	2,767	61,182	328,697	56,885	38,227
053 OCCUPATIONAL THERAPY	64,747	5,384	2,767	17,199	90,097	15,592	38,227
054 SPEECH PATHOLOGY	6,274	1,318	677	1,667	9,936	1,720	9,359
055 ELECTROCARDIOLOGY	103,927	2,584	1,328	7,488	115,327	19,959	18,345
056 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED	227,137				227,137	39,309	
055 30 IMPL. DEV. CHARGED TO PAT	3,905				3,905	676	
056 DRUGS CHARGED TO PATIENTS	1,163,031				1,163,031	201,275	
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
062 EMERGENCY	663,260	10,919	5,612	93,761	773,552	133,872	77,525
065 OBSERVATION BEDS (NON-DIS							
066 OTHER REIMBURS COST CNTRS							
067 AMBULANCE SERVICES							
071 DURABLE MEDICAL EQUIP-REN							
095 DURABLE MEDICAL EQUIP-SOL							
095 HOME HEALTH AGENCY							
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	21,412,418	326,503	167,810	2,707,781	21,110,341	3,099,070	1,729,809
096 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP		1,266	651		1,917	332	8,986
100 PHYSICIANS' PRIVATE OFFIC		6,027	3,097		9,124	1,579	42,790
101 FOUNDATION/ MOBS	298,252			291,036	589,288	101,983	
102 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	21,710,670	333,796	171,558	2,998,817	21,710,670	3,202,964	1,781,585

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY
	9	10	11	12	14	15	16
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE	181,605						
011 HOUSEKEEPING	1,855	550,039					
012 DIETARY	4,301		319,576				
014 CAFETERIA			280,105	1,030,144			
015 NURSING ADMINISTRATION		11,703		42,951	910,069		
016 CENTRAL SERVICES & SUPPLY						41,892	
017 PHARMACY				38,253			1,230,038
018 MEDICAL RECORDS & LIBRARY		6,615		36,911			
025 SOCIAL SERVICE		3,816		14,093			
026 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	70,476	222,865	34,290	357,027	618,335		
033 INTENSIVE CARE UNIT	14,939	44,013	5,181	75,164	130,176		
037 NURSERY		5,851		7,382	12,785		
038 ANCILLARY SRVC COST CNTRS							
039 OPERATING ROOM	19,740	62,331		44,293	76,711		
040 RECOVERY ROOM							
041 DELIVERY ROOM & LABOR ROO		8,396		2,684			
042 ANESTHESIOLOGY				11,409			
044 RADIOLOGY-DIAGNOSTIC	16,212	26,459		111,403			
045 RADIOLOGY-THERAPEUTIC							
048 LABORATORY		23,660		122,812			
049 PBP CLINICAL LAB SERVICES							
050 INTRAVENOUS THERAPY							
051 RESPIRATORY THERAPY		13,993		63,755			
052 PHYSICAL THERAPY	15,148	7,378		33,555			
053 OCCUPATIONAL THERAPY							
054 SPEECH PATHOLOGY		2,035		7,382			
055 ELECTROCARDIOLOGY							
055 30 ELECTROENCEPHALOGRAPHY		4,834				41,184	
056 MEDICAL SUPPLIES CHARGED						708	
060 IMPL. DEV. CHARGED TO PAT		1,272					
061 DRUGS CHARGED TO PATIENTS				19,462			1,230,038
062 OUTPAT SERVICE COST CNTRS							
065 CLINIC							
066 EMERGENCY	30,833	83,193		41,608	72,062		
067 OBSERVATION BEDS (NON-DIS							
071 OTHER REIMBURS COST CNTRS							
095 AMBULANCE SERVICES							
096 DURABLE MEDICAL EQUIP-REN							
098 DURABLE MEDICAL EQUIP-SOL							
100 HOME HEALTH AGENCY							
101 SPEC PURPOSE COST CENTERS							
102 SUBTOTALS	173,504	528,414	319,576	1,030,144	910,069	41,892	1,230,038
103 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP							
098 PHYSICIANS' PRIVATE OFFIC	8,101	21,625					
100 FOUNDATION/ MOBS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	181,605	550,039	319,576	1,030,144	910,069	41,892	1,230,038

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	SUBTOTAL	I&R COST POST STEP-DOWN ADJ 26	TOTAL
	17	18	25		27
003 GENERAL SERVICE COST CNTR					
004 NEW CAP REL COSTS-BLDG &					
005 NEW CAP REL COSTS-MVBLE E					
006 EMPLOYEE BENEFITS					
008 ADMINISTRATIVE & GENERAL					
009 OPERATION OF PLANT					
010 LAUNDRY & LINEN SERVICE					
011 HOUSEKEEPING					
012 DIETARY					
014 CAFETERIA					
015 NURSING ADMINISTRATION					
016 CENTRAL SERVICES & SUPPLY					
017 PHARMACY					
018 MEDICAL RECORDS & LIBRARY	442,119				
025 SOCIAL SERVICE		191,576			
026 INPAT ROUTINE SRVC CNTRS					
033 ADULTS & PEDIATRICS	131,364	16,076	5,660,118		5,660,118
037 INTENSIVE CARE UNIT	13,419	175,500	1,688,371		1,688,371
038 NURSERY			98,061		98,061
039 ANCILLARY SRVC COST CNTRS					
040 OPERATING ROOM			1,140,395		1,140,395
041 RECOVERY ROOM					
042 DELIVERY ROOM & LABOR ROO	26,132		200,743		200,743
044 ANESTHESIOLOGY			477,357		477,357
045 RADIOLOGY-DIAGNOSTIC	76,982		2,543,204		2,543,204
048 RADIOLOGY-THERAPEUTIC					
049 LABORATORY			3,115,977		3,115,977
050 PBP CLINICAL LAB SERVICES					
051 INTRAVENOUS THERAPY			853,152		853,152
052 RESPIRATORY THERAPY			479,890		479,890
053 PHYSICAL THERAPY			143,916		143,916
054 OCCUPATIONAL THERAPY			21,015		21,015
055 SPEECH PATHOLOGY			357,270		357,270
056 ELECTROCARDIOLOGY	194,222				
060 ELECTROENCEPHALOGRAPHY			312,464		312,464
061 MEDICAL SUPPLIES CHARGED			5,289		5,289
062 30 IMPL. DEV. CHARGED TO PAT			2,615,078		2,615,078
065 DRUGS CHARGED TO PATIENTS					
066 OUTPAT SERVICE COST CNTRS					
071 CLINIC			1,212,645		1,212,645
095 EMERGENCY					
096 OBSERVATION BEDS (NON-DIS					
098 OTHER REIMBURS COST CNTRS					
100 AMBULANCE SERVICES					
101 DURABLE MEDICAL EQUIP-REN					
102 DURABLE MEDICAL EQUIP-SOL					
103 HOME HEALTH AGENCY					
095 SPEC PURPOSE COST CENTERS					
096 SUBTOTALS	442,119	191,576	20,924,945		20,924,945
098 NONREIMBURS COST CENTERS					
100 GIFT, FLOWER, COFFEE SHOP			11,235		11,235
101 PHYSICIANS' PRIVATE OFFIC			83,219		83,219
102 FOUNDATION/ MOBS			691,271		691,271
103 CROSS FOOT ADJUSTMENT					
102 NEGATIVE COST CENTER					
103 TOTAL	442,119	191,576	21,710,670		21,710,670

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO:
I 15-1317
I

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

I PREPARED 5/26/2011
I WORKSHEET B
I PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
	0	3	4	4a	5	6	8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL		50,738	26,077	76,815		76,815	
009 OPERATION OF PLANT		32,134	16,515	48,649		6,303	54,952
010 LAUNDRY & LINEN SERVICE		4,328	2,225	6,553		534	948
011 HOUSEKEEPING		3,187	1,638	4,825		1,859	698
012 DIETARY		19,647	10,098	29,745		622	4,303
014 CAFETERIA		11,988	6,161	18,149		2,352	2,625
015 NURSING ADMINISTRATION		3,004	1,544	4,548		2,951	658
016 CENTRAL SERVICES & SUPPLY		4,545	2,336	6,881		34	995
017 PHARMACY		5,194	2,669	7,863		4,086	1,137
018 MEDICAL RECORDS & LIBRARY		6,610	3,397	10,007		1,244	1,448
025 SOCIAL SERVICE		1,620	833	2,453		574	355
026 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS		59,458	30,562	90,020		13,406	13,022
033 INTENSIVE CARE UNIT		17,175	8,827	26,002		3,920	3,761
037 NURSERY		3,345	1,719	5,064		171	732
038 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM		28,435	14,614	43,049		2,602	6,227
039 RECOVERY ROOM							
040 DELIVERY ROOM & LABOR ROO		13,667	7,024	20,691		235	2,993
041 ANESTHESIOLOGY						1,648	
042 RADIOLOGY-DIAGNOSTIC		20,172	10,368	30,540		7,673	4,418
044 RADIOLOGY-THERAPEUTIC							
045 LABORATORY		12,670	6,512	19,182		10,187	2,775
048 PBP CLINICAL LAB SERVICES							
049 INTRAVENOUS THERAPY							
050 RESPIRATORY THERAPY		2,997	1,540	4,537		2,668	656
051 PHYSICAL THERAPY		5,384	2,767	8,151		1,364	1,179
052 OCCUPATIONAL THERAPY		5,384	2,767	8,151		374	1,179
053 SPEECH PATHOLOGY		1,318	677	1,995		41	289
054 ELECTROCARDIOLOGY		2,584	1,328	3,912		479	566
055 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED						943	
055 30 IMPL. DEV. CHARGED TO PAT						16	
056 DRUGS CHARGED TO PATIENTS						4,827	
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
062 EMERGENCY		10,919	5,612	16,531		3,210	2,391
065 OBSERVATION BEDS (NON-DIS							
066 OTHER REIMBURS COST CNTRS							
067 AMBULANCE SERVICES							
071 DURABLE MEDICAL EQUIP-REN							
095 DURABLE MEDICAL EQUIP-SOL							
095 HOME HEALTH AGENCY							
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS		326,503	167,810	494,313		74,323	53,355
096 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP		1,266	651	1,917		8	277
100 PHYSICIANS' PRIVATE OFFIC		6,027	3,097	9,124		38	1,320
101 FOUNDATION/ MOBS						2,446	
102 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		333,796	171,558	505,354		76,815	54,952

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY
	9	10	11	12	14	15	16
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE	8,035						
011 HOUSEKEEPING	82	7,464					
012 DIETARY	190		34,860				
014 CAFETERIA			30,555	53,681			
015 NURSING ADMINISTRATION		159		2,238	10,554		
016 CENTRAL SERVICES & SUPPLY						7,910	
017 PHARMACY				1,993			15,079
018 MEDICAL RECORDS & LIBRARY		90		1,923			
025 SOCIAL SERVICE		52		734			
026 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	3,120	3,024	3,740	18,605	7,170		
033 INTENSIVE CARE UNIT	661	597	565	3,917	1,510		
037 NURSERY		79		385	148		
038 ANCILLARY SRVC COST CNTRS							
039 OPERATING ROOM	873	846		2,308	890		
040 RECOVERY ROOM							
041 DELIVERY ROOM & LABOR ROO		114		140			
042 ANESTHESIOLOGY				595			
044 RADIOLOGY-DIAGNOSTIC	717	359		5,805			
045 RADIOLOGY-THERAPEUTIC							
048 LABORATORY		321		6,400			
049 PBP CLINICAL LAB SERVICES							
050 INTRAVENOUS THERAPY		190		3,322			
051 RESPIRATORY THERAPY		100		1,749			
052 PHYSICAL THERAPY	670						
053 OCCUPATIONAL THERAPY							
054 SPEECH PATHOLOGY		28		385			
055 ELECTROCARDIOLOGY							
055 30 MEDICAL SUPPLIES CHARGED		66				7,776	
056 IMPL. DEV. CHARGED TO PAT						134	
060 DRUGS CHARGED TO PATIENTS		17		1,014			15,079
061 OUTPAT SERVICE COST CNTRS							
062 CLINIC							
065 EMERGENCY	1,364	1,129		2,168	836		
066 OBSERVATION BEDS (NON-DIS							
067 OTHER REIMBURS COST CNTRS							
071 AMBULANCE SERVICES							
095 DURABLE MEDICAL EQUIP-REN							
095 DURABLE MEDICAL EQUIP-SOL							
095 HOME HEALTH AGENCY							
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	7,677	7,171	34,860	53,681	10,554	7,910	15,079
096 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP							
100 PHYSICIANS' PRIVATE OFFIC	358	293					
101 FOUNDATION/ MOBS							
102 CROSS FOOT ADJUSTMENTS							
103 NEGATIVE COST CENTER							
103 TOTAL	8,035	7,464	34,860	53,681	10,554	7,910	15,079

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1317 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART III

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	17	18	25	26	27
003 GENERAL SERVICE COST CNTR					
004 NEW CAP REL COSTS-BLDG &					
005 NEW CAP REL COSTS-MVBLE E					
006 EMPLOYEE BENEFITS					
008 ADMINISTRATIVE & GENERAL					
009 OPERATION OF PLANT					
010 LAUNDRY & LINEN SERVICE					
011 HOUSEKEEPING					
012 DIETARY					
014 CAFETERIA					
015 NURSING ADMINISTRATION					
016 CENTRAL SERVICES & SUPPLY					
017 PHARMACY					
018 MEDICAL RECORDS & LIBRARY	14,712				
025 SOCIAL SERVICE		4,168			
026 INPAT ROUTINE SRVC CNTRS					
033 ADULTS & PEDIATRICS	4,371	350	156,828		156,828
037 INTENSIVE CARE UNIT	447	3,818	45,198		45,198
038 NURSERY			6,579		6,579
039 ANCILLARY SRVC COST CNTRS					
040 OPERATING ROOM			56,795		56,795
041 RECOVERY ROOM					
042 DELIVERY ROOM & LABOR ROO	870		25,043		25,043
044 ANESTHESIOLOGY			2,243		2,243
045 RADIOLOGY-DIAGNOSTIC	2,562		52,074		52,074
048 RADIOLOGY-THERAPEUTIC					
049 LABORATORY			38,865		38,865
050 PBP CLINICAL LAB SERVICES					
051 INTRAVENOUS THERAPY			11,373		11,373
052 RESPIRATORY THERAPY			13,213		13,213
053 PHYSICAL THERAPY			9,704		9,704
054 OCCUPATIONAL THERAPY			2,325		2,325
055 SPEECH PATHOLOGY	6,462		11,832		11,832
056 ELECTROCARDIOLOGY					
060 ELECTROENCEPHALOGRAPHY			8,785		8,785
061 MEDICAL SUPPLIES CHARGED			150		150
062 30 IMPL. DEV. CHARGED TO PAT			20,937		20,937
065 DRUGS CHARGED TO PATIENTS					
066 OUTPAT SERVICE COST CNTRS					
067 CLINIC			27,629		27,629
071 EMERGENCY					
095 OBSERVATION BEDS (NON-DIS					
096 OTHER REIMBURS COST CNTRS					
098 AMBULANCE SERVICES					
100 DURABLE MEDICAL EQUIP-REN					
101 DURABLE MEDICAL EQUIP-SOL					
102 HOME HEALTH AGENCY					
103 SPEC PURPOSE COST CENTERS					
095 SUBTOTALS	14,712	4,168	489,573		489,573
096 NONREIMBURS COST CENTERS					
098 GIFT, FLOWER, COFFEE SHOP			2,202		2,202
100 PHYSICIANS' PRIVATE OFFIC			11,133		11,133
101 FOUNDATION/ MOBS			2,446		2,446
102 CROSS FOOT ADJUSTMENTS					
103 NEGATIVE COST CENTER					
103 TOTAL	14,712	4,168	505,354		505,354

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	S RECONCIL-) IATION	ADMINISTRATIV	OPERATION OF
	OSTS-BLDG &	OSTS-MVBLE E	FITS		E & GENERAL	PLANT
	(SQUARE FEET	(SQUARE) FEET	(GROSS)ALARIES		(ACCUM. COST	(SQUARE) FEET
	3	4	5	6a.00	6	8
GENERAL SERVICE COST						
003 NEW CAP REL COSTS-BLD	50,900					
004 NEW CAP REL COSTS-MVB		50,900				
005 EMPLOYEE BENEFITS			11,289,051			
006 ADMINISTRATIVE & GENE	7,737	7,737	1,120,991	-3,202,964	18,507,706	
008 OPERATION OF PLANT	4,900	4,900	372,307		1,518,749	38,263
009 LAUNDRY & LINEN SERVI	660	660			128,616	660
010 HOUSEKEEPING	486	486	295,811		448,020	486
011 DIETARY	2,996	2,996	52,262		149,845	2,996
012 CAFETERIA	1,828	1,828	343,156		566,828	1,828
014 NURSING ADMINISTRATIO	458	458	519,404		711,037	458
015 CENTRAL SERVICES & SU	693	693			8,205	693
016 PHARMACY	792	792	629,718		984,525	792
017 MEDICAL RECORDS & LIB	1,008	1,008	193,468		299,779	1,008
018 SOCIAL SERVICE	247	247	107,289		138,242	247
INPAT ROUTINE SRVC CN						
025 ADULTS & PEDIATRICS	9,067	9,067	2,401,624		3,228,741	9,067
026 INTENSIVE CARE UNIT	2,619	2,619	694,318		944,566	2,619
033 NURSERY	510	510	27,209		41,172	510
ANCILLARY SRVC COST C						
037 OPERATING ROOM	4,336	4,336	348,892		626,932	4,336
038 RECOVERY ROOM						
039 DELIVERY ROOM & LABOR	2,084	2,084	25,501		56,687	2,084
040 ANESTHESIOLOGY			301,322		397,207	
041 RADIOLOGY-DIAGNOSTIC	3,076	3,076	830,337		1,848,945	3,076
042 RADIOLOGY-THERAPEUTIC						
044 LABORATORY	1,932	1,932	770,561		2,454,730	1,932
045 PBP CLINICAL LAB SERV						
048 INTRAVENOUS THERAPY						
049 RESPIRATORY THERAPY	457	457	476,779		642,869	457
050 PHYSICAL THERAPY	821	821	230,321		328,697	821
051 OCCUPATIONAL THERAPY	821	821	64,747		90,097	821
052 SPEECH PATHOLOGY	201	201	6,274		9,936	201
053 ELECTROCARDIOLOGY	394	394	28,187		115,327	394
054 ELECTROENCEPHALOGRAPH						
055 MEDICAL SUPPLIES CHAR					227,137	
30 055 IMPL. DEV. CHARGED TO					3,905	
056 DRUGS CHARGED TO PATI					1,163,031	
OUTPAT SERVICE COST C						
060 CLINIC						
061 EMERGENCY	1,665	1,665	352,965		773,552	1,665
062 OBSERVATION BEDS (NON						
OTHER REIMBURS COST C						
065 AMBULANCE SERVICES						
066 DURABLE MEDICAL EQUIP						
067 DURABLE MEDICAL EQUIP						
071 HOME HEALTH AGENCY						
SPEC PURPOSE COST CEN						
095 SUBTOTALS	49,788	49,788	10,193,443	-3,202,964	17,907,377	37,151
NONREIMBURS COST CENT						
096 GIFT, FLOWER, COFFEE	193	193			1,917	193
098 PHYSICIANS' PRIVATE O	919	919			9,124	919
100 FOUNDATION/ MOBS			1,095,608		589,288	
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	333,796	171,558	2,998,817		3,202,964	1,781,585
(WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	6.557878		.265639		.173061	
(WRKSHT B, PT I)		3.370491				46.561561
105 COST TO BE ALLOCATED						
(WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
(WRKSHT B, PT II)						
107 COST TO BE ALLOCATED					76,815	54,952
(WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER					.004150	1.436165
(WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	R)
		(POUNDS OF DRY)	LAU)	(HOURS OF SERVICE)	(MEALS SERVED)	S(HOURS)	(DIRECT)SING HRS	NR(COSTED)EQUIS.	
		9	10	11	12	14	15	16	
003	GENERAL SERVICE COST								
004	NEW CAP REL COSTS-BLD								
005	NEW CAP REL COSTS-MVB								
006	EMPLOYEE BENEFITS								
008	ADMINISTRATIVE & GENE								
009	OPERATION OF PLANT								
010	LAUNDRY & LINEN SERVI	19,973							
011	HOUSEKEEPING	204	2,162						
012	DIETARY	473		92,405					
014	CAFETERIA			80,992	1,535				
015	NURSING ADMINISTRATIO		46		64	783			
016	CENTRAL SERVICES & SU						231,042		
017	PHARMACY				57				100
018	MEDICAL RECORDS & LIB		26		55				
025	SOCIAL SERVICE		15		21				
026	INPAT ROUTINE SRVC CN								
033	ADULTS & PEDIATRICS	7,751	876	9,915	532	532			
037	INTENSIVE CARE UNIT	1,643	173	1,498	112	112			
038	NURSERY		23		11	11			
039	ANCILLARY SRVC COST C								
040	OPERATING ROOM	2,171	245		66	66			
041	RECOVERY ROOM								
042	DELIVERY ROOM & LABOR		33		4				
044	ANESTHESIOLOGY				17				
045	RADIOLOGY-DIAGNOSTIC	1,783	104		166				
048	RADIOLOGY-THERAPEUTIC								
049	LABORATORY		93		183				
050	PBP CLINICAL LAB SERV								
051	INTRAVENOUS THERAPY								
052	RESPIRATORY THERAPY		55		95				
053	PHYSICAL THERAPY	1,666	29		50				
054	OCCUPATIONAL THERAPY								
055	SPEECH PATHOLOGY								
056	ELECTROCARDIOLOGY		8		11				
060	ELECTROENCEPHALOGRAPH								
061	MEDICAL SUPPLIES CHAR		19				227,137		
062	30 IMPL. DEV. CHARGED TO						3,905		
065	DRUGS CHARGED TO PATI		5		29				100
066	OUTPAT SERVICE COST C								
067	CLINIC								
071	EMERGENCY	3,391	327		62	62			
095	OBSERVATION BEDS (NON								
096	OTHER REIMBURS COST C								
098	AMBULANCE SERVICES								
100	DURABLE MEDICAL EQUIP								
101	DURABLE MEDICAL EQUIP								
102	HOME HEALTH AGENCY								
103	SPEC PURPOSE COST CEN								
104	SUBTOTALS	19,082	2,077	92,405	1,535	783	231,042		100
105	NONREIMBURS COST CENT								
106	GIFT, FLOWER, COFFEE								
107	PHYSICIANS' PRIVATE O	891	85						
108	FOUNDATION/ MOBS								
109	CROSS FOOT ADJUSTMENT								
110	NEGATIVE COST CENTER								
111	COST TO BE ALLOCATED	181,605	550,039	319,576	1,030,144	910,069	41,892	1,230,038	
112	(WRKSHT B, PART I)								
113	UNIT COST MULTIPLIER	9.092525	254.412118	3.458428	671.103583	1,162.284802	.181318	12,300.380000	
114	(WRKSHT B, PT I)								
115	COST TO BE ALLOCATED								
116	(WRKSHT B, PART II)								
117	UNIT COST MULTIPLIER	8,035	7,464	34,860	53,681	10,554	7,910	15,079	
118	(WRKSHT B, PT II)								
119	COST TO BE ALLOCATED								
120	(WRKSHT B, PART III)								
121	UNIT COST MULTIPLIER	.402293	3.452359	.377252	34.971336	13.478927	.034236	150.790000	
122	(WRKSHT B, PT III)								

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1317 I FROM 1/ 1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
	(TIME SPENT	(TIME SPENT)
	17	18
GENERAL SERVICE COST		
003 NEW CAP REL COSTS-BLD		
004 NEW CAP REL COSTS-MVB		
005 EMPLOYEE BENEFITS		
006 ADMINISTRATIVE & GENE		
008 OPERATION OF PLANT		
009 LAUNDRY & LINEN SERVI		
010 HOUSEKEEPING		
011 DIETARY		
012 CAFETERIA		
014 NURSING ADMINISTRATIO		
015 CENTRAL SERVICES & SU		
016 PHARMACY		
017 MEDICAL RECORDS & LIB	626	
018 SOCIAL SERVICE		143
INPAT ROUTINE SRVC CN		
025 ADULTS & PEDIATRICS	186	12
026 INTENSIVE CARE UNIT	19	131
033 NURSERY		
ANCILLARY SRVC COST C		
037 OPERATING ROOM		
038 RECOVERY ROOM		
039 DELIVERY ROOM & LABOR	37	
040 ANESTHESIOLOGY		
041 RADIOLOGY-DIAGNOSTIC	109	
042 RADIOLOGY-THERAPEUTIC		
044 LABORATORY		
045 PBP CLINICAL LAB SERV		
048 INTRAVENOUS THERAPY		
049 RESPIRATORY THERAPY		
050 PHYSICAL THERAPY		
051 OCCUPATIONAL THERAPY		
052 SPEECH PATHOLOGY		
053 ELECTROCARDIOLOGY	275	
054 ELECTROENCEPHALOGRAPH		
055 MEDICAL SUPPLIES CHAR		
056 30 IMPL. DEV. CHARGED TO		
DRUGS CHARGED TO PATI		
OUTPAT SERVICE COST C		
060 CLINIC		
061 EMERGENCY		
062 OBSERVATION BEDS (NON		
OTHER REIMBURS COST C		
065 AMBULANCE SERVICES		
066 DURABLE MEDICAL EQUIP		
067 DURABLE MEDICAL EQUIP		
071 HOME HEALTH AGENCY		
SPEC PURPOSE COST CEN		
095 SUBTOTALS	626	143
NONREIMBURS COST CENT		
096 GIFT, FLOWER, COFFEE		
098 PHYSICIANS' PRIVATE O		
100 FOUNDATION/ MOBS		
101 CROSS FOOT ADJUSTMENT		
102 NEGATIVE COST CENTER		
103 COST TO BE ALLOCATED	442,119	191,576
(PER WRKSHT B, PART		
UNIT COST MULTIPLIER		1,339.692308
(WRKSHT B, PT I)	706.260383	
105 COST TO BE ALLOCATED		
(PER WRKSHT B, PART		
UNIT COST MULTIPLIER		
(WRKSHT B, PT II)		
107 COST TO BE ALLOCATED	14,712	4,168
(PER WRKSHT B, PART		
UNIT COST MULTIPLIER		29.146853
(WRKSHT B, PT III)	23.501597	

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO:
I 15-1317
II PERIOD:
I FROM 1/ 1/2010
I TO 12/31/2010I PREPARED 5/26/2011
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	5,660,118		5,660,118		
26	INTENSIVE CARE UNIT	1,688,371		1,688,371		
33	NURSERY	98,061		98,061		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,140,395		1,140,395		
38	RECOVERY ROOM					
39	DELIVERY ROOM & LABOR ROO	200,743		200,743		
40	ANESTHESIOLOGY	477,357		477,357		
41	RADIOLOGY-DIAGNOSTIC	2,543,204		2,543,204		
42	RADIOLOGY-THERAPEUTIC					
44	LABORATORY	3,115,977		3,115,977		
45	PBP CLINICAL LAB SERVICES					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	853,152		853,152		
50	PHYSICAL THERAPY	479,890		479,890		
51	OCCUPATIONAL THERAPY	143,916		143,916		
52	SPEECH PATHOLOGY	21,015		21,015		
53	ELECTROCARDIOLOGY	357,270		357,270		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	312,464		312,464		
55	30 IMPL. DEV. CHARGED TO PAT	5,289		5,289		
56	DRUGS CHARGED TO PATIENTS	2,615,078		2,615,078		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	1,212,645		1,212,645		
62	OBSERVATION BEDS (NON-DIS	986,420		986,420		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
66	DURABLE MEDICAL EQUIP-REN					
67	DURABLE MEDICAL EQUIP-SOL					
101	SUBTOTAL	21,911,365		21,911,365		
102	LESS OBSERVATION BEDS	986,420		986,420		
103	TOTAL	20,924,945		20,924,945		

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	2,298,595		2,298,595			
26	INTENSIVE CARE UNIT	543,150		543,150			
33	NURSERY	153,105		153,105			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	399,088	1,753,186	2,152,274	.529856	.529856	
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO	51,363	30,818	82,181	2.442694	2.442694	
40	ANESTHESIOLOGY	149,882	288,511	438,393	1.088879	1.088879	
41	RADIOLOGY-DIAGNOSTIC	884,271	9,690,975	10,575,246	.240487	.240487	
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY	1,133,668	8,454,813	9,588,481	.324971	.324971	
45	PBP CLINICAL LAB SERVICES						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	401,538	121,149	522,687	1.632243	1.632243	
50	PHYSICAL THERAPY	66,094	799,405	865,499	.554466	.554466	
51	OCCUPATIONAL THERAPY	21,710	148,888	170,598	.843597	.843597	
52	SPEECH PATHOLOGY	13,561	18,778	32,339	.649835	.649835	
53	ELECTROCARDIOLOGY	304,798	1,176,173	1,480,971	.241240	.241240	
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	843,724	637,711	1,481,435	.210920	.210920	
55	30 IMPL. DEV. CHARGED TO PAT		48,180	48,180	.109776	.109776	
56	DRUGS CHARGED TO PATIENTS	1,558,247	4,362,748	5,920,995	.441662	.441662	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	61,195	3,630,589	3,691,784	.328471	.328471	
62	OBSERVATION BEDS (NON-DIS		725,090	725,090	1.360410	1.360410	
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	8,883,989	31,887,014	40,771,003			
102	LESS OBSERVATION BEDS						
103	TOTAL	8,883,989	31,887,014	40,771,003			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO:
I 15-1317
I

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

I PREPARED 5/26/2011
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	5,660,118		5,660,118		
26	INTENSIVE CARE UNIT	1,688,371		1,688,371		
33	NURSERY	98,061		98,061		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,140,395		1,140,395		
38	RECOVERY ROOM					
39	DELIVERY ROOM & LABOR ROO	200,743		200,743		
40	ANESTHESIOLOGY	477,357		477,357		
41	RADIOLOGY-DIAGNOSTIC	2,543,204		2,543,204		
42	RADIOLOGY-THERAPEUTIC					
44	LABORATORY	3,115,977		3,115,977		
45	PBP CLINICAL LAB SERVICES					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	853,152		853,152		
50	PHYSICAL THERAPY	479,890		479,890		
51	OCCUPATIONAL THERAPY	143,916		143,916		
52	SPEECH PATHOLOGY	21,015		21,015		
53	ELECTROCARDIOLOGY	357,270		357,270		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	312,464		312,464		
55	30 IMPL. DEV. CHARGED TO PAT	5,289		5,289		
56	DRUGS CHARGED TO PATIENTS	2,615,078		2,615,078		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	1,212,645		1,212,645		
62	OBSERVATION BEDS (NON-DIS	986,420		986,420		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
66	DURABLE MEDICAL EQUIP-REN					
67	DURABLE MEDICAL EQUIP-SOL					
101	SUBTOTAL	21,911,365		21,911,365		
102	LESS OBSERVATION BEDS	986,420		986,420		
103	TOTAL	20,924,945		20,924,945		

COMPUTATION OF RATIO OF COSTS TO CHARGES
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS						
26	ADULTS & PEDIATRICS	2,298,595		2,298,595			
26	INTENSIVE CARE UNIT	543,150		543,150			
33	NURSERY	153,105		153,105			
37	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	399,088	1,753,186	2,152,274	.529856	.529856	
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO	51,363	30,818	82,181	2.442694	2.442694	
40	ANESTHESIOLOGY	149,882	288,511	438,393	1.088879	1.088879	
41	RADIOLOGY-DIAGNOSTIC	884,271	9,690,975	10,575,246	.240487	.240487	
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY	1,133,668	8,454,813	9,588,481	.324971	.324971	
45	PBP CLINICAL LAB SERVICES						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	401,538	121,149	522,687	1.632243	1.632243	
50	PHYSICAL THERAPY	66,094	799,405	865,499	.554466	.554466	
51	OCCUPATIONAL THERAPY	21,710	148,888	170,598	.843597	.843597	
52	SPEECH PATHOLOGY	13,561	18,778	32,339	.649835	.649835	
53	ELECTROCARDIOLOGY	304,798	1,176,173	1,480,971	.241240	.241240	
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	843,724	637,711	1,481,435	.210920	.210920	
55	30 IMPL. DEV. CHARGED TO PAT		48,180	48,180	.109776	.109776	
56	DRUGS CHARGED TO PATIENTS	1,558,247	4,362,748	5,920,995	.441662	.441662	
60	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	61,195	3,630,589	3,691,784	.328471	.328471	
62	OBSERVATION BEDS (NON-DIS		725,090	725,090	1.360410	1.360410	
62	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	8,883,989	31,887,014	40,771,003			
102	LESS OBSERVATION BEDS						
103	TOTAL	8,883,989	31,887,014	40,771,003			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	1,140,395	56,795	1,083,600			1,140,395
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO	200,743	25,043	175,700			200,743
40	ANESTHESIOLOGY	477,357	2,243	475,114			477,357
41	RADIOLOGY-DIAGNOSTIC	2,543,204	52,074	2,491,130			2,543,204
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY	3,115,977	38,865	3,077,112			3,115,977
45	PBP CLINICAL LAB SERVICES						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	853,152	11,373	841,779			853,152
50	PHYSICAL THERAPY	479,890	13,213	466,677			479,890
51	OCCUPATIONAL THERAPY	143,916	9,704	134,212			143,916
52	SPEECH PATHOLOGY	21,015	2,325	18,690			21,015
53	ELECTROCARDIOLOGY	357,270	11,832	345,438			357,270
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	312,464	8,785	303,679			312,464
55	30 IMPL. DEV. CHARGED TO PAT	5,289	150	5,139			5,289
56	DRUGS CHARGED TO PATIENTS	2,615,078	20,937	2,594,141			2,615,078
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	1,212,645	27,629	1,185,016			1,212,645
62	OBSERVATION BEDS (NON-DIS	986,420		986,420			986,420
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	14,464,815	280,968	14,183,847			14,464,815
102	LESS OBSERVATION BEDS	986,420		986,420			986,420
103	TOTAL	13,478,395	280,968	13,197,427			13,478,395

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	2,152,274	.529856	.529856
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROO	82,181	2.442694	2.442694
40	ANESTHESIOLOGY	438,393	1.088879	1.088879
41	RADIOLOGY-DIAGNOSTIC	10,575,246	.240487	.240487
42	RADIOLOGY-THERAPEUTIC			
44	LABORATORY	9,588,481	.324971	.324971
45	PBP CLINICAL LAB SERVICES			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	522,687	1.632243	1.632243
50	PHYSICAL THERAPY	865,499	.554466	.554466
51	OCCUPATIONAL THERAPY	170,598	.843597	.843597
52	SPEECH PATHOLOGY	32,339	.649835	.649835
53	ELECTROCARDIOLOGY	1,480,971	.241240	.241240
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	1,481,435	.210920	.210920
55	30 IMPL. DEV. CHARGED TO PAT	48,180	.109776	.109776
56	DRUGS CHARGED TO PATIENTS	5,920,995	.441662	.441662
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	3,691,784	.328471	.328471
62	OBSERVATION BEDS (NON-DIS	725,090	1.360410	1.360410
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-REN			
67	DURABLE MEDICAL EQUIP-SOL			
101	SUBTOTAL	37,776,153		
102	LESS OBSERVATION BEDS	725,090		
103	TOTAL	37,051,063		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	1,140,395	56,795	1,083,600			1,140,395
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO	200,743	25,043	175,700			200,743
40	ANESTHESIOLOGY	477,357	2,243	475,114			477,357
41	RADIOLOGY-DIAGNOSTIC	2,543,204	52,074	2,491,130			2,543,204
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY	3,115,977	38,865	3,077,112			3,115,977
45	PBP CLINICAL LAB SERVICES						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	853,152	11,373	841,779			853,152
50	PHYSICAL THERAPY	479,890	13,213	466,677			479,890
51	OCCUPATIONAL THERAPY	143,916	9,704	134,212			143,916
52	SPEECH PATHOLOGY	21,015	2,325	18,690			21,015
53	ELECTROCARDIOLOGY	357,270	11,832	345,438			357,270
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	312,464	8,785	303,679			312,464
55	30 IMPL. DEV. CHARGED TO PAT	5,289	150	5,139			5,289
56	DRUGS CHARGED TO PATIENTS	2,615,078	20,937	2,594,141			2,615,078
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	1,212,645	27,629	1,185,016			1,212,645
62	OBSERVATION BEDS (NON-DIS	986,420		986,420			986,420
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	14,464,815	280,968	14,183,847			14,464,815
102	LESS OBSERVATION BEDS	986,420		986,420			986,420
103	TOTAL	13,478,395	280,968	13,197,427			13,478,395

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	2,152,274	.529856	.529856
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROO	82,181	2.442694	2.442694
40	ANESTHESIOLOGY	438,393	1.088879	1.088879
41	RADIOLOGY-DIAGNOSTIC	10,575,246	.240487	.240487
42	RADIOLOGY-THERAPEUTIC			
44	LABORATORY	9,588,481	.324971	.324971
45	PBP CLINICAL LAB SERVICES			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	522,687	1.632243	1.632243
50	PHYSICAL THERAPY	865,499	.554466	.554466
51	OCCUPATIONAL THERAPY	170,598	.843597	.843597
52	SPEECH PATHOLOGY	32,339	.649835	.649835
53	ELECTROCARDIOLOGY	1,480,971	.241240	.241240
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	1,481,435	.210920	.210920
55	30 IMPL. DEV. CHARGED TO PAT	48,180	.109776	.109776
56	DRUGS CHARGED TO PATIENTS	5,920,995	.441662	.441662
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	3,691,784	.328471	.328471
62	OBSERVATION BEDS (NON-DIS	725,090	1.360410	1.360410
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-REN			
67	DURABLE MEDICAL EQUIP-SOL			
101	SUBTOTAL	37,776,153		
102	LESS OBSERVATION BEDS	725,090		
103	TOTAL	37,051,063		

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	.529856		.529856		
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM	2.442694		2.442694		
40 ANESTHESIOLOGY	1.088879		1.088879		
41 RADIOLOGY-DIAGNOSTIC	.240487		.240487		
42 RADIOLOGY-THERAPEUTIC					
44 LABORATORY	.324971		.324971		
45 PBP CLINICAL LAB SERVICES-PRGM ONLY					
48 INTRAVENOUS THERAPY					
49 RESPIRATORY THERAPY	1.632243		1.632243		
50 PHYSICAL THERAPY	.554466		.554466		
51 OCCUPATIONAL THERAPY	.843597		.843597		
52 SPEECH PATHOLOGY	.649835		.649835		
53 ELECTROCARDIOLOGY	.241240		.241240		
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.210920		.210920		
55 30 IMPL. DEV. CHARGED TO PATIENT	.109776		.109776		
56 DRUGS CHARGED TO PATIENTS	.441662		.441662		
OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY	.328471		.328471		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.360410		1.360410		
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES					
66 DURABLE MEDICAL EQUIP-RENTED					
67 DURABLE MEDICAL EQUIP-SOLD					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES					

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

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic 4	All Other (1) 5	Outpatient Ambulatory Surgical Ctr 6	Outpatient Radiology 7	Other Outpatient Diagnostic 8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		787,041			
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY		41,778			
41 RADIOLOGY-DIAGNOSTIC		3,900,756			
42 RADIOLOGY-THERAPEUTIC					
44 LABORATORY		4,267,540			
45 PBP CLINICAL LAB SERVICES-PRGM ONLY					
48 INTRAVENOUS THERAPY					
49 RESPIRATORY THERAPY		37,552			
50 PHYSICAL THERAPY		242,045			
51 OCCUPATIONAL THERAPY		66,291			
52 SPEECH PATHOLOGY		6,641			
53 ELECTROCARDIOLOGY		680,789			
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		242,278			
55 30 IMPL. DEV. CHARGED TO PATIENT		34,992			
56 DRUGS CHARGED TO PATIENTS		2,284,627			
OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY		1,234,918			
62 OBSERVATION BEDS (NON-DISTINCT PART)		267,645			
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES					
66 DURABLE MEDICAL EQUIP-RENTED					
67 DURABLE MEDICAL EQUIP-SOLD					
101 SUBTOTAL		14,094,893			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS--					
PROGRAM ONLY CHARGES					
104 NET CHARGES		14,094,893			

(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	417,018		
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM			
40	ANESTHESIOLOGY	45,491		
41	RADIOLOGY-DIAGNOSTIC	938,081		
42	RADIOLOGY-THERAPEUTIC			
44	LABORATORY	1,386,827		
45	PBP CLINICAL LAB SERVICES-PRGM ONLY			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	61,294		
50	PHYSICAL THERAPY	134,206		
51	OCCUPATIONAL THERAPY	55,923		
52	SPEECH PATHOLOGY	4,316		
53	ELECTROCARDIOLOGY	164,234		
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,101		
55	30 IMPL. DEV. CHARGED TO PATIENT	3,841		
56	DRUGS CHARGED TO PATIENTS	1,009,033		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	405,635		
62	OBSERVATION BEDS (NON-DISTINCT PART)	364,107		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD			
101	SUBTOTAL	5,041,107		
102	CRNA CHARGES			
103	LESS, PBP CLINIC LAB SVCS-			
	PROGRAM ONLY CHARGES			
104	NET CHARGES	5,041,107		

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

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,388
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,212
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,212
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	123
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	53
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,020
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	123
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	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	5,660,118
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	7,685
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	216,155
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,443,963

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,500,210
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,500,210
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	2.177402
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	778.40
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	5,443,963

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 1,694.88
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 3,423,658
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 3,423,658

	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	1,688,371	304	5,553.85	298	1,655,047
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1,732,154
49 TOTAL PROGRAM INPATIENT COSTS					6,810,859

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) 208,470
 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 208,470
 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	582
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,694.88
85	OBSERVATION BED COST	986,420

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,388
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,212
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,212
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	123
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	53
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)	157
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)	173
16	NURSERY DAYS (TITLE V OR XIX ONLY)	114

SWING-BED ADJUSTMENT

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

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,500,210
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,500,210
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	778.40
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	

TITLE XIX - I/P HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

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

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY) INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS		173		114	
43 INTENSIVE CARE UNIT		304		6	
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					1
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					366,370
49 TOTAL PROGRAM INPATIENT COSTS					366,370

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 366,370

TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES 78
 55 TARGET AMOUNT PER DISCHARGE
 56 TARGET AMOUNT
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
 58 BONUS PAYMENT
 58.01 LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED
 AND COMPOUNDED BY THE MARKET BASKET
 58.02 LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET
 BASKET
 58.03 IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE
 LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN
 EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56)
 OTHERWISE ENTER ZERO.
 58.04 RELIEF PAYMENT
 59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
 59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
 59.02 PROGRAM DISCHARGES PRIOR TO JULY 1
 59.03 PROGRAM DISCHARGES AFTER JULY 1
 59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)
 59.05 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1
 (SEE INSTRUCTIONS) (LTCH ONLY)
 59.06 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
 (SEE INSTRUCTIONS) (LTCH ONLY)
 59.07 REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
 59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

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

TITLE XIX - I/P HOSPITAL OTHER

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

1

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

PART IV - COMPUTATION OF OBSERVATION BED COST

- 83 TOTAL OBSERVATION BED DAYS 582
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM
- 85 OBSERVATION BED COST

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	OTHER	
			INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		1,799,048	
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS		455,965	
37	OPERATING ROOM	.529856	133,280	70,619
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM	2.442694		
40	ANESTHESIOLOGY	1.088879	25,725	28,011
41	RADIOLOGY-DIAGNOSTIC	.240487	677,269	162,874
42	RADIOLOGY-THERAPEUTIC			
44	LABORATORY	.324971	836,444	271,820
45	PBP CLINICAL LAB SERVICES-PRGM ONLY			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	1.632243	277,164	452,399
50	PHYSICAL THERAPY	.554466	42,599	23,620
51	OCCUPATIONAL THERAPY	.843597	13,324	11,240
52	SPEECH PATHOLOGY	.649835	12,068	7,842
53	ELECTROCARDIOLOGY	.241240	293,289	70,753
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.210920	47,638	10,048
55	30 IMPL. DEV. CHARGED TO PATIENT	.109776		
56	DRUGS CHARGED TO PATIENTS	.441662	1,409,865	622,684
60	OUTPAT SERVICE COST CNTRS CLINIC			
61	EMERGENCY	.328471	744	244
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS	1.360410		
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD			
101	TOTAL		3,769,409	1,732,154
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		3,769,409	

TITLE XVIII, PART A

SWING BED SNF

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.529856		
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM	2.442694		
40	ANESTHESIOLOGY	1.088879		
41	RADIOLOGY-DIAGNOSTIC	.240487	4,085	982
42	RADIOLOGY-THERAPEUTIC			
44	LABORATORY	.324971	10,591	3,442
45	PBP CLINICAL LAB SERVICES-PRGM ONLY			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	1.632243	9,577	15,632
50	PHYSICAL THERAPY	.554466	11,345	6,290
51	OCCUPATIONAL THERAPY	.843597	7,160	6,040
52	SPEECH PATHOLOGY	.649835	400	260
53	ELECTROCARDIOLOGY	.241240	4,216	1,017
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.210920	19,886	4,194
55	30 IMPL. DEV. CHARGED TO PATIENT	.109776		
56	DRUGS CHARGED TO PATIENTS	.441662	28,945	12,784
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.328471		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.360410		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD			
101	TOTAL		96,205	50,641
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		96,205	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

WKST A LINE NO.	TITLE XIX COST CENTER DESCRIPTION	HOSPITAL	OTHER		
			RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			209,488	
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS			21,420	
37	OPERATING ROOM		.529856	179,263	94,984
38	RECOVERY ROOM				
39	DELIVERY ROOM & LABOR ROOM		2.442694	43,145	105,390
40	ANESTHESIOLOGY		1.088879	2,100	2,287
41	RADIOLOGY-DIAGNOSTIC		.240487	85,219	20,494
42	RADIOLOGY-THERAPEUTIC				
44	LABORATORY		.324971	143,191	46,533
45	PBP CLINICAL LAB SERVICES-PRGM ONLY				
48	INTRAVENOUS THERAPY				
49	RESPIRATORY THERAPY		1.632243	12,414	20,263
50	PHYSICAL THERAPY		.554466	2,910	1,613
51	OCCUPATIONAL THERAPY		.843597	872	736
52	SPEECH PATHOLOGY		.649835		
53	ELECTROCARDIOLOGY		.241240	7,293	1,759
54	ELECTROENCEPHALOGRAPHY				
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		.210920	61,846	13,045
55	30 IMPL. DEV. CHARGED TO PATIENT		.109776		
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS		.441662	119,437	52,751
60	CLINIC				
61	EMERGENCY		.328471	19,835	6,515
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS		1.360410		
65	AMBULANCE SERVICES				
66	DURABLE MEDICAL EQUIP-RENTED				
67	DURABLE MEDICAL EQUIP-SOLD				
101	TOTAL			677,525	366,370
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES				
103	NET CHARGES			677,525	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) 5,041,295
 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) 5,041,295

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) 5,091,708
 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18 CAH DEDUCTIBLES 29,877
 18.01 CAH ACTUAL BILLED COINSURANCE 1,987,899
 LINE 17.01 (SEE INSTRUCTIONS)
 19 SUBTOTAL (SEE INSTRUCTIONS) 3,073,932
 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 3,073,932
 24 PRIMARY PAYER PAYMENTS 828
 25 SUBTOTAL 3,073,104

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26 COMPOSITE RATE ESRD
 27 BAD DEBTS (SEE INSTRUCTIONS) 329,961
 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) 329,961
 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES 329,961
 28 SUBTOTAL 3,403,065
 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 3,403,065
 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)
 34 INTERIM PAYMENTS 3,293,825
 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)
 35 BALANCE DUE PROVIDER/PROGRAM 109,240
 36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) 81,332
 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	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		5,088,539		3,480,176
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01	8/12/2010	555,328		
ADJUSTMENTS TO PROVIDER .02	12/23/2010	143,346		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROVIDER .49				
ADJUSTMENTS TO PROGRAM .50			8/12/2010	62,749
ADJUSTMENTS TO PROGRAM .51			12/23/2010	123,602
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		698,674		-186,351
4 TOTAL INTERIM PAYMENTS		5,787,213		3,293,825
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) .01		685,116		109,240
BASED ON COST REPORT (1)				
7 TOTAL MEDICARE PROGRAM LIABILITY		6,472,329		3,403,065

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		196,820		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01	8/12/2010	19,065		
ADJUSTMENTS TO PROVIDER .02	12/23/2010	22,785		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROVIDER .49				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		41,850		NONE
4 TOTAL INTERIM PAYMENTS		238,670		
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		17,669		
AMOUNT (BALANCE DUE)				
BASED ON COST REPORT (1)				
7 TOTAL MEDICARE PROGRAM LIABILITY		256,339		

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 5/26/2011
I	15-1317	I	FROM 1/ 1/2010	I	
I	COMPONENT NO:	I	TO 12/31/2010	I	WORKSHEET E-2
I	15-Z317	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)	210,555	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	51,147	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	123	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	261,702	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	261,702	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	261,702	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	5,363	
14	80% OF PART B COSTS		
15	SUBTOTAL	256,339	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	256,339	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	238,670	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	17,669	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	5,846	

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	6,810,859
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	6,810,859
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	6,878,968
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	6,878,968
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	488,545
21	EXCESS REASONABLE COST	
22	SUBTOTAL	6,390,423
23	COINSURANCE	2,200
24	SUBTOTAL	6,388,223
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	84,106
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	84,106
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	84,106
26	SUBTOTAL	6,472,329
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	6,472,329
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	5,787,213
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	685,116
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	149,912

CALCULATION OF REIMBURSEMENT SETTLEMENT

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

	TITLE XIX	HOSPITAL	TITLE V OR TITLE XIX	TITLE XVIII SNF PPS
			1	2
	COMPUTATION OF NET COST OF COVERED SERVICE			
1	INPATIENT HOSPITAL/SNF/NF SERVICES		366,370	
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		366,370	
7	INPATIENT PRIMARY PAYER PAYMENTS			
8	OUTPATIENT PRIMARY PAYER PAYMENTS			
9	SUBTOTAL		366,370	
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
10	ROUTINE SERVICE CHARGES			
11	ANCILLARY SERVICE CHARGES		677,525	
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		677,525	
	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)		677,525	
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		311,155	
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
23	COST OF COVERED SERVICES		366,370	
	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		366,370	
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		366,370	
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34	EXCESS OF REASONABLE COST			
35	SUBTOTAL		366,370	
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)		366,370	
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		366,370	
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER		366,370	
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
57	INTERIM PAYMENTS		366,370	
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			
58	BALANCE DUE PROVIDER/PROGRAM			

BALANCE SHEET

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	4,281,134			
2 TEMPORARY INVESTMENTS	2,228,705			
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	12,061,539			
5 OTHER RECEIVABLES				
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7 INVENTORY	337,766			
8 PREPAID EXPENSES	165,360			
9 OTHER CURRENT ASSETS				
10 DUE FROM OTHER FUNDS	5,331,867			
11 TOTAL CURRENT ASSETS	24,406,371			
FIXED ASSETS				
12 LAND	759,198			
12.01				
13 LAND IMPROVEMENTS	477,277			
13.01 LESS ACCUMULATED DEPRECIATION	-421,644			
14 BUILDINGS	7,255,971			
14.01 LESS ACCUMULATED DEPRECIATION	-5,460,055			
15 LEASEHOLD IMPROVEMENTS				
15.01 LESS ACCUMULATED DEPRECIATION				
16 FIXED EQUIPMENT	960,111			
16.01 LESS ACCUMULATED DEPRECIATION	-775,930			
17 AUTOMOBILES AND TRUCKS				
17.01 LESS ACCUMULATED DEPRECIATION				
18 MAJOR MOVABLE EQUIPMENT	3,323,840			
18.01 LESS ACCUMULATED DEPRECIATION	-2,805,126			
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE				
21 TOTAL FIXED ASSETS	3,313,642			
OTHER ASSETS				
22 INVESTMENTS				
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS				
26 TOTAL OTHER ASSETS				
27 TOTAL ASSETS	27,720,013			

BALANCE SHEET

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	359,706			
29 SALARIES, WAGES & FEES PAYABLE	841,418			
30 PAYROLL TAXES PAYABLE	188,703			
31 NOTES AND LOANS PAYABLE (SHORT TERM)				
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS	2,498,324			
35 OTHER CURRENT LIABILITIES				
36 TOTAL CURRENT LIABILITIES	3,888,151			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE				
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES				
42 TOTAL LONG-TERM LIABILITIES				
43 TOTAL LIABILITIES	3,888,151			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	23,831,862			
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	23,831,862			
52 TOTAL LIABILITIES AND FUND BALANCES	27,720,013			

STATEMENT OF CHANGES IN FUND BALANCES

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	FUND BALANCE AT BEGINNING		21,664,606		
	OF PERIOD				
2	NET INCOME (LOSS)		1,631,157		
3	TOTAL		23,295,763		
4	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
	PRIOR PERIOD ADJUSTMENTS-	536,099			
5					
6					
7					
8					
9					
10	TOTAL ADDITIONS		536,099		
11	SUBTOTAL		23,831,862		
12	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13	DEDUCTIONS (DEBIT ADJUSTM				
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF		23,831,862		
	PERIOD PER BALANCE SHEET				

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	FUND BALANCE AT BEGINNING				
	OF PERIOD				
2	NET INCOME (LOSS)				
3	TOTAL				
4	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
	PRIOR PERIOD ADJUSTMENTS-				
5					
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	2,500,210		2,500,210
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	2,500,210		2,500,210
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT	543,150		543,150
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	543,150		543,150
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	3,043,360		3,043,360
17 00 ANCILLARY SERVICES	5,449,951	35,202,062	40,652,013
18 00 OUTPATIENT SERVICES			
19 00 HOME HEALTH AGENCY			
20 00 AMBULANCE SERVICES			
24 00			
25 00 TOTAL PATIENT REVENUES	8,493,311	35,202,062	43,695,373

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		22,805,305	
ADD (SPECIFY)			
27 00 BAD DEBT	2,303,330		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		2,303,330	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		25,108,635	

DESCRIPTION

1	TOTAL PATIENT REVENUES	43,695,373
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	18,500,975
3	NET PATIENT REVENUES	25,194,398
4	LESS: TOTAL OPERATING EXPENSES	25,108,635
5	NET INCOME FROM SERVICE TO PATIENTS	85,763
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	22,085
7	INCOME FROM INVESTMENTS	61,032
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	239,910
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	5,251
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	-2,500
23	GOVERNMENTAL APPROPRIATIONS	
24	BIOTERRORISM GRANT	33,376
24.01	MISC INCOME	22,919
24.02	DSH PAYMENT	1,162,683
24.03	CPR TRAINING	638
24.04		
25	TOTAL OTHER INCOME	1,545,394
26	TOTAL	1,631,157
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	1,631,157