

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 5
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	15-1304	I	FROM 1/ 1/2010	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 12/31/2010	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/27/2011 TIME 15:26

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:

RUSH MEMORIAL HOSPITAL 15-1304
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 15:26

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PI ENCRYPTION INFORMATION
DATE: 5/27/2011 TIME 15:26

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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	-154,845	107,979	71,210
3	SWING BED - SNF	0	-104,614	0	0
100	TOTAL	0	-259,459	107,979	71,210

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: 1300 NORTH MAIN STREET P.O. BOX:
 1.01 CITY: RUSHVILLE STATE: IN ZIP CODE: 46173- COUNTY: RUSH

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;					PAYMENT SYSTEM (P,T,O OR N)		
COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	V	XVIII	XIX
02.00	HOSPITAL	15-1304	2.01	8/ 1/2000	4	5	6
04.00	SWING BED - SNF	RUSH SWING BEDS	15-2304	8/ 1/2000	N	0	N

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

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL
 20 SUBPROVIDER

OTHER INFORMATION

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

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

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

21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 N Y 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) N
 25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE
 RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y"
 FOR YES OR "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS) N
 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 UNWEIGHTED NUMBER OF NON-PRIMARY CARE FTE
 RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. 0.00

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

25.09 0000 0.00
 26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT
 IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01.
 SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0
 26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /
 26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /
 27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913
 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. N / /

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

28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. 1 2 3 4
 ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE
 OCTOBER 1ST (SEE INSTRUCTIONS) 0 0.0000 0.0000

28.02 ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL
 INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER
 THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR
 TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE
 OR TWO CHARACTER CODE IF RURAL BASED FACILITY 0.00 0

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

28.03 STAFFING 0.00% Y/N
 28.04 RECRUITMENT 0.00%
 28.05 RETENTION 0.00%
 28.06 TRAINING 0.00%

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

31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42
 CFR 412.113(c). N
 31.01 IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42
 CFR 412.113(c). N
 31.02 IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42
 CFR 412.113(c). N
 31.03 IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42
 CFR 412.113(c). N
 31.04 IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42
 CFR 412.113(c). N
 31.05 IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42
 CFR 412.113(c). N

MISCELLANEOUS COST REPORT INFORMATION

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

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

TITLE XIX INPATIENT SERVICES

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

- 40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS). N

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

- 41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y
- 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? 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? N
- 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? N
- 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD? N
- 46 IF YOU ARE PARTICIPATING IN THE NHCMP DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS). N

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: 234,859
 PAID LOSSES: 0
 AND/OR SELF INSURANCE: 0
- 54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N
- 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

	DATE 0	Y OR N 1	LIMIT 2	Y OR N 3	FEES 4
56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		N	0.00		0
56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?		N			
58 ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.		N			
58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).				0	
59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)		N			
60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)		N			
60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(C)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC).				0	

MULTICAMPUS

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

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

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00

SETTLEMENT DATA

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

MISCELLANEOUS DATA

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

HOSPITAL AND HOSPITAL HEALTH CARE
 COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET S-3
 I TO 12/31/2010 I PART I

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	I/P DAYS / TITLE V 3	O/P VISITS / TITLE XVIII 4	NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1 ADULTS & PEDIATRICS	15	5,475	131,400.00		1,016		91
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF					623		
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	15	5,475	131,400.00		1,639		91
6 INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL	15	5,475	131,400.00		1,639		91
13 RPCH VISITS							
14 SUBPROVIDER							
18 HOME HEALTH AGENCY							
21 HOSPICE							
25 TOTAL	15						
26 OBSERVATION BED DAYS							91
27 AMBULANCE TRIPS					7,282		
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	TITLE XIX ADMITTED 5.01	I/P DAYS / OBSERVATION NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	/ TRIPS TOTAL OBSERVATION ADMITTED 6.01	DISCHARGES TOTAL OBSERVATION NOT ADMITTED 6.02	-- INTERNS & RES. FTES -- TOTAL 7	-- LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			1,533				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			623				
4 ADULTS & PED-SB NF			97				
5 TOTAL ADULTS AND PEDS			2,253				
6 INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL			2,253				
13 RPCH VISITS							
14 SUBPROVIDER							
18 HOME HEALTH AGENCY							
21 HOSPICE							
25 TOTAL							
26 OBSERVATION BED DAYS			499				
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 EMPLOYEES ON PAYROLL 10	EQUIV NONPAID WORKERS 11	DISCHARGES TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS					329	27	507
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		230.39			329	27	507
13 RPCH VISITS							
14 SUBPROVIDER							
18 HOME HEALTH AGENCY							
21 HOSPICE							
25 TOTAL		230.39					
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 EXPENSESI PROVIDER NO:
I 15-1304
II PERIOD:
I FROM 1/ 1/2010
I TO 12/31/2010I PREPARED 5/27/2011
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		1,667,515	1,667,515		1,667,515
5	0500 EMPLOYEE BENEFITS	167,441	1,973,049	2,140,490	7,955	2,148,445
6	0600 ADMINISTRATIVE & GENERAL	1,940,412	871,578	2,811,990		2,811,990
8	0800 OPERATION OF PLANT	184,024	462,712	646,736	-47,583	599,153
9	0900 LAUNDRY & LINEN SERVICE				50,083	50,083
10	1000 HOUSEKEEPING	236,448	122,847	359,295		359,295
11	1100 DIETARY	322,781	264,159	586,940	-418,680	168,260
12	1200 CAFETERIA				418,680	418,680
14	1400 NURSING ADMINISTRATION	97,597	1,180	98,777	-48,000	50,777
15	1500 CENTRAL SERVICES & SUPPLY	46,170	204,775	250,945	-166,141	84,804
16	1600 PHARMACY					
17	1700 MEDICAL RECORDS & LIBRARY	234,963	94,677	329,640		329,640
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	858,880	68,716	927,596	526	928,122
26	2600 INTENSIVE CARE UNIT					
31	3100 SUBPROVIDER					
33	3300 NURSERY					
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	296,236	408,476	704,712	-33,196	671,516
38	3800 RECOVERY ROOM		3,533	3,533	33,196	36,729
39	3900 DELIVERY ROOM & LABOR ROOM					
40	4000 ANESTHESIOLOGY					
41	4100 RADIOLOGY-DIAGNOSTIC	785,028	976,824	1,761,852	32,016	1,793,868
42	4200 RADIOLOGY-THERAPEUTIC					
43	4300 RADIOISOTOPE					
44	4400 LABORATORY	545,500	722,697	1,268,197		1,268,197
45	4500 PBP CLINICAL LAB SERVICES-PRGM ONLY					
46	4600 WHOLE BLOOD & PACKED RED BLOOD CELLS					
47	4700 BLOOD STORING, PROCESSING & TRANS.					
48	4800 INTRAVENOUS THERAPY					
49	4900 RESPIRATORY THERAPY	132,506	6,523	139,029		139,029
50	5000 PHYSICAL THERAPY	318,679	105,055	423,734		423,734
51	5100 OCCUPATIONAL THERAPY	214,639	586	215,225		215,225
52	5200 SPEECH PATHOLOGY	2,469		2,469		2,469
53	5300 ELECTROCARDIOLOGY	171,251	3,289	174,540	28,886	203,426
54	5400 ELECTROENCEPHALOGRAPHY					
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		13,976	13,976	111,558	125,534
55.30	5530 IMPL. DEV. CHARGED TO PATIENT		8,313	8,313	54,583	62,896
56	5600 DRUGS CHARGED TO PATIENTS	250,399	1,292,354	1,542,753		1,542,753
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	77,528	18,284	95,812		95,812
61	6100 EMERGENCY	797,845	541,349	1,339,194	21,308	1,360,502
61.01	6101 EMERGENCY PHYSICIAN					
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
65	6500 AMBULANCE SERVICES	591,638	76,084	667,722	-8,350	659,372
71	7100 HOME HEALTH AGENCY					
	SPEC PURPOSE COST CENTERS					
93	9300 HOSPICE					
95	9500 SUBTOTALS	8,272,434	9,908,551	18,180,985	36,841	18,217,826
	NONREIMBURS COST CENTERS					
98	9800 PHYSICIANS' PRIVATE OFFICES	2,284,143	498,766	2,782,909		2,782,909
99	9900 NONPAID WORKERS					
99.01	9901 FOUNDATION	55,631	1,489	57,120		57,120
99.02	9902 OCCUPATIONAL MEDICINE	41,671	8,076	49,747	-36,841	12,906
100	7950 OTHER NONREIMBURSABLE COST CENTERS					
101	TOTAL	10,653,879	10,416,882	21,070,761	-0-	21,070,761

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSESI PROVIDER NO:
I 15-1304
II PERIOD:
I FROM 1/ 1/2010 I PREPARED 5/27/2011
I TO 12/31/2010 I WORKSHEET A

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-17,482	1,650,033
5	0500 EMPLOYEE BENEFITS	-1,120	2,147,325
6	0600 ADMINISTRATIVE & GENERAL	-184,088	2,627,902
8	0800 OPERATION OF PLANT		599,153
9	0900 LAUNDRY & LINEN SERVICE		50,083
10	1000 HOUSEKEEPING		359,295
11	1100 DIETARY	-2,633	165,627
12	1200 CAFETERIA	-192,800	225,880
14	1400 NURSING ADMINISTRATION		50,777
15	1500 CENTRAL SERVICES & SUPPLY	-866	83,938
16	1600 PHARMACY		
17	1700 MEDICAL RECORDS & LIBRARY	-10,758	318,882
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS		928,122
26	2600 INTENSIVE CARE UNIT		
31	3100 SUBPROVIDER		
33	3300 NURSERY		
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM	-320,386	351,130
38	3800 RECOVERY ROOM		36,729
39	3900 DELIVERY ROOM & LABOR ROOM		
40	4000 ANESTHESIOLOGY		
41	4100 RADIOLOGY-DIAGNOSTIC	-567,719	1,226,149
42	4200 RADIOLOGY-THERAPEUTIC		
43	4300 RADIOISOTOPE		
44	4400 LABORATORY	-959	1,267,238
45	4500 PBP CLINICAL LAB SERVICES-PRGM ONLY		
46	4600 WHOLE BLOOD & PACKED RED BLOOD CELLS		
47	4700 BLOOD STORING, PROCESSING & TRANS.		
48	4800 INTRAVENOUS THERAPY		
49	4900 RESPIRATORY THERAPY		139,029
50	5000 PHYSICAL THERAPY		423,734
51	5100 OCCUPATIONAL THERAPY		215,225
52	5200 SPEECH PATHOLOGY		2,469
53	5300 ELECTROCARDIOLOGY		203,426
54	5400 ELECTROENCEPHALOGRAPHY		
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	-383	125,151
55.30	5530 IMPL. DEV. CHARGED TO PATIENT		62,896
56	5600 DRUGS CHARGED TO PATIENTS	-892	1,541,861
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC		95,812
61	6100 EMERGENCY		1,360,502
61.01	6101 EMERGENCY PHYSICIAN		
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
	OTHER REIMBURS COST CNTRS		
65	6500 AMBULANCE SERVICES		659,372
71	7100 HOME HEALTH AGENCY		
	SPEC PURPOSE COST CENTERS		
93	9300 HOSPICE		
95	9500 SUBTOTALS	-1,300,086	16,917,740
	NONREIMBURS COST CENTERS		
98	9800 PHYSICIANS' PRIVATE OFFICES		2,782,909
99	9900 NONPAID WORKERS		
99.01	9901 FOUNDATION		57,120
99.02	9902 OCCUPATIONAL MEDICINE		12,906
100	7950 OTHER NONREIMBURSABLE COST CENTERS		
101	TOTAL	-1,300,086	19,770,675

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I NOT A CMS WORKSHEET
 I I TO 12/31/2010 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
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	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
31	SUBPROVIDER	3100	
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	
43	RADIOISOTOPE	4300	
44	LABORATORY	4400	
45	PBP CLINICAL LAB SERVICES-PRGM ONLY	4500	
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	4600	
47	BLOOD STORING, PROCESSING & TRANS.	4700	
48	INTRAVENOUS THERAPY	4800	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
54	ELECTROENCEPHALOGRAPHY	5400	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
55.30	IMPL. DEV. CHARGED TO PATIENT	5530	IMPL. DEV. CHARGED TO PATIENT
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
61.01	EMERGENCY PHYSICIAN	6101	EMERGENCY
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
93	HOSPICE	9300	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
98	PHYSICIANS' PRIVATE OFFICES	9800	
99	NONPAID WORKERS	9900	
99.01	FOUNDATION	9901	NONPAID WORKERS
99.02	OCCUPATIONAL MEDICINE	9902	NONPAID WORKERS
100	OTHER NONREIMBURSABLE COST CENTERS	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO: 151304	PERIOD: FROM 1/ 1/2010 TO 12/31/2010	PREPARED 5/27/2011 WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1) 1	COST CENTER 2	LINE NO 3	SALARY 4	OTHER 5
1 SALARY RECLASS	A	EMPLOYEE BENEFITS	5	7,955	
2		RECOVERY ROOM	38	33,196	
3		RADIOLOGY-DIAGNOSTIC	41	32,016	
4		ELECTROCARDIOLOGY	53	28,886	
5		EMERGENCY	61	15,984	
6 LAUNDRY & LINEN	B	LAUNDRY & LINEN SERVICE	9		50,083
7 CAFETERIA RECLASS	C	CAFETERIA	12	230,248	188,432
8 MED SUPPLY	D	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		166,141
9 AMBULANCE RECLASS	E	OPERATION OF PLANT	8	2,500	
10		ADULTS & PEDIATRICS	25	526	
11		EMERGENCY	61	5,324	
12 IMPLANTABLE SUPPLIES	F	IMPL. DEV. CHARGED TO PATIENT	55.30		54,583
36 TOTAL RECLASSIFICATIONS				356,635	459,239

(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: 151304	PERIOD: FROM 1/ 1/2010 TO 12/31/2010	PREPARED 5/27/2011 WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION	----- DECREASE -----				A-7 REF 10
	CODE (1)	COST CENTER 6	LINE NO 7	SALARY 8	
1 SALARY RECLASS	A	NURSING ADMINISTRATION	14	48,000	
2		OPERATING ROOM	37	33,196	
3		OCCUPATIONAL MEDICINE	99.02	36,841	
4					
5					
6 LAUNDRY & LINEN	B	OPERATION OF PLANT	8		50,083
7 CAFETERIA RECLASS	C	DIETARY	11	230,248	188,432
8 MED SUPPLY	D	CENTRAL SERVICES & SUPPLY	15		166,141
9 AMBULANCE RECLASS	E	AMBULANCE SERVICES	65	8,350	
10					
11					
12 IMPLANTABLE SUPPLIES	F	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		54,583
36 TOTAL RECLASSIFICATIONS				356,635	459,239

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151304	FROM 1/ 1/2010	5/27/2011
	TO 12/31/2010	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : SALARY RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	EMPLOYEE BENEFITS	5	7,955	NURSING ADMINISTRATION	14	48,000	
2.00	RECOVERY ROOM	38	33,196	OPERATING ROOM	37	33,196	
3.00	RADIOLOGY-DIAGNOSTIC	41	32,016	OCCUPATIONAL MEDICINE	99.02	36,841	
4.00	ELECTROCARDIOLOGY	53	28,886			0	
5.00	EMERGENCY	61	15,984			0	
TOTAL RECLASSIFICATIONS FOR CODE A			118,037				118,037

RECLASS CODE: B
EXPLANATION : LAUNDRY & LINEN

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	LAUNDRY & LINEN SERVICE	9	50,083	OPERATION OF PLANT	8	50,083	
TOTAL RECLASSIFICATIONS FOR CODE B			50,083				50,083

RECLASS CODE: C
EXPLANATION : CAFETERIA RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	CAFETERIA	12	418,680	DIETARY	11	418,680	
TOTAL RECLASSIFICATIONS FOR CODE C			418,680				418,680

RECLASS CODE: D
EXPLANATION : MED SUPPLY

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	166,141	CENTRAL SERVICES & SUPPLY	15	166,141	
TOTAL RECLASSIFICATIONS FOR CODE D			166,141				166,141

RECLASS CODE: E
EXPLANATION : AMBULANCE RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	OPERATION OF PLANT	8	2,500	AMBULANCE SERVICES	65	8,350	
2.00	ADULTS & PEDIATRICS	25	526			0	
3.00	EMERGENCY	61	5,324			0	
TOTAL RECLASSIFICATIONS FOR CODE E			8,350				8,350

RECLASS CODE: F
EXPLANATION : IMPLANTABLE SUPPLIES

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	IMPL. DEV. CHARGED TO PATIENT	55.30	54,583	MEDICAL SUPPLIES CHARGED TO PA	55	54,583	
TOTAL RECLASSIFICATIONS FOR CODE F			54,583				54,583

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	164,978					164,978	
2 LAND IMPROVEMENTS	226,758	9,040		9,040		235,798	
3 BUILDINGS & FIXTURE	11,948,586	51,632		51,632		12,000,218	
4 BUILDING IMPROVEMEN	60,592	6,136		6,136	9,002	57,726	
5 FIXED EQUIPMENT	601,313	84,077		84,077		685,390	
6 MOVABLE EQUIPMENT	10,090,024	425,899		425,899		10,515,923	
7 SUBTOTAL	23,092,251	576,784		576,784	9,002	23,660,033	
8 RECONCILING ITEMS							
9 TOTAL	23,092,251	576,784		576,784	9,002	23,660,033	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL	
		GROSS ASSETS	CAPITIALIZED LEASES	GROSS ASSETS FOR RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS		
		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL								
5	TOTAL				1.000000			1,667,515	

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	1,353,942		218,280	77,811			1,650,033
5	TOTAL	1,353,942		218,280	77,811			1,650,033

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	1,371,424		218,280	77,811			1,667,515
5	TOTAL	1,371,424		218,280	77,811			1,667,515

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: I 15-1304
I

I PERIOD: I PREPARED 5/27/2011
I FROM 1/ 1/2010 I WORKSHEET A-8
I TO 12/31/2010 I

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON		WKST. A-7 REF. 5
			WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED	LINE NO	
	1	2	COST CENTER	3	4
1			**COST CENTER DELETED**		1
2			**COST CENTER DELETED**		2
3			NEW CAP REL COSTS-BLDG &		3
4			**COST CENTER DELETED**		4
5					
6					
7					
8					
9					
10					
11					
12	A-8-2	-886,949			
13					
14	A-8-1				
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25	A-8-3/A-8-4		RESPIRATORY THERAPY		49
26	A-8-3/A-8-4		PHYSICAL THERAPY		50
27	A-8-3				
28			**COST CENTER DELETED**		89
29			**COST CENTER DELETED**		1
30			**COST CENTER DELETED**		2
31			NEW CAP REL COSTS-BLDG &		3
32			**COST CENTER DELETED**		4
33			**COST CENTER DELETED**		20
34					
35	A-8-4		OCCUPATIONAL THERAPY		51
36	A-8-4		SPEECH PATHOLOGY		52
37	B	-90,438	CAFETERIA		12
38	B	-102,362	CAFETERIA		12
39	B	-1,610	ADMINISTRATIVE & GENERAL		6
40	B	-383	MEDICAL SUPPLIES CHARGED		55
41	B	-8,250	ADMINISTRATIVE & GENERAL		6
42	B	-221	EMPLOYEE BENEFITS		5
43	B	-10,758	MEDICAL RECORDS & LIBRARY		17
44	B	-8,590	ADMINISTRATIVE & GENERAL		6
45	B	-16,000	ADMINISTRATIVE & GENERAL		6
46	B	-959	LABORATORY		44
47	B	-9,942	ADMINISTRATIVE & GENERAL		6
48	B	-90	EMPLOYEE BENEFITS		5
49	B	-893	DIETARY		11
49.01	B	-718	RADIOLOGY-DIAGNOSTIC		41
49.02	B	-17,482	NEW CAP REL COSTS-BLDG &		3
49.03	A	-3,442	ADMINISTRATIVE & GENERAL		6
49.04	A	-777	ADMINISTRATIVE & GENERAL		6
49.05	A	-546	ADMINISTRATIVE & GENERAL		6
49.06	A	-130,136	ADMINISTRATIVE & GENERAL		6
49.07	A	-3,157	ADMINISTRATIVE & GENERAL		6
49.08	B	-809	EMPLOYEE BENEFITS		5
49.09	B	-1,638	ADMINISTRATIVE & GENERAL		6
49.10	B	-1,740	DIETARY		11
49.11	B	-438	RADIOLOGY-DIAGNOSTIC		41
49.12	B	-866	CENTRAL SERVICES & SUPPLY		15
49.13	B	-892	DRUGS CHARGED TO PATIENTS		56
50		-1,300,086			

(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						
2						
3						
4						
5	TOTALS					

* 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		0.00		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 PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET A-8-2
 I I TO 12/31/2010 I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1 37	OPERATING ROOM	29,072	24,072	5,000				
2 37	ANESTHESIA	298,900	296,314	2,586				
3 41	RADIOLOGY	493,817	468,817	25,000				
4 41	ULTRASOUND	16,643	16,643					
5 41	ONCOLOGY	81,103	81,103					
6 44	LABORATORY	36,000		36,000				
7 61	EMERGENCY ROOM	472,695		472,695				
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	1,428,230	886,949	541,281				

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 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	7	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS	SALARIES	NOT ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	7	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	7	SQUARE	FEET	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	11	FTE'S		ENTERED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED	REQUIS.	ENTERED
16	PHARMACY	15	COSTED	REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME	SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE
	0	3	5	5a.00	6	8	9
003 GENERAL SERVICE COST CNTR							
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS	1,650,033	1,650,033					
006 ADMINISTRATIVE & GENERAL	2,147,325		2,162,842				
008 OPERATION OF PLANT	2,627,902	319,993	400,517	3,348,412	3,348,412		
009 LAUNDRY & LINEN SERVICE	599,153	162,614	38,500	800,267	163,170	963,437	
010 HOUSEKEEPING	50,083	6,886		56,969	11,616	5,759	74,344
011 DIETARY	359,295	33,593	48,805	441,693	90,059	28,097	5,218
012 CAFETERIA	165,627	64,743	19,100	249,470	50,866	54,150	2,139
014 NURSING ADMINISTRATION	225,880	21,496	47,525	294,901	60,129	17,979	
015 CENTRAL SERVICES & SUPPLY	50,777	10,376	10,237	71,390	14,556	8,678	
016 PHARMACY	83,938	45,993	9,530	139,461	28,435	38,467	
017 MEDICAL RECORDS & LIBRARY							
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	928,122	144,282	177,388	1,249,792	254,826	120,675	48,475
031 INTENSIVE CARE UNIT							
033 SUBPROVIDER NURSERY							
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM	351,130	113,109	54,294	518,533	105,726	94,602	4,866
039 RECOVERY ROOM	36,729	14,540	6,852	58,121	11,851	12,161	
040 DELIVERY ROOM & LABOR ROO							
041 ANESTHESIOLOGY							
042 RADIOLOGY-DIAGNOSTIC	1,226,149	162,544	168,644	1,557,337	317,533	135,950	3,144
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
045 LABORATORY	1,267,238	48,412	112,596	1,428,246	291,212	40,491	
046 PBP CLINICAL LAB SERVICES							
047 WHOLE BLOOD & PACKED RED							
048 BLOOD STORING, PROCESSING							
049 INTRAVENOUS THERAPY							
050 RESPIRATORY THERAPY	139,029	3,048	27,350	169,427	34,545	2,549	626
051 PHYSICAL THERAPY	423,734	85,029	65,778	574,541	117,146	71,117	1,464
052 OCCUPATIONAL THERAPY	215,225	25,730	44,303	285,258	58,163	21,520	673
053 SPEECH PATHOLOGY	2,469	465	510	3,444	702	389	29
054 ELECTROCARDIOLOGY	203,426	9,352	41,310	254,088	51,807	7,822	
055 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED	125,151			125,151	25,518		
056 30 IMPL. DEV. CHARGED TO PAT	62,896			62,896	12,824		
060 DRUGS CHARGED TO PATIENTS	1,541,861	8,282	51,684	1,601,827	326,605	6,927	
061 OUTPAT SERVICE COST CNTRS							
062 CLINIC	95,812	60,509	16,002	172,323	35,136	50,609	
065 EMERGENCY	1,360,502	87,100	169,080	1,616,682	329,633	72,849	7,710
061 01 EMERGENCY PHYSICIAN							
062 OBSERVATION BEDS (NON-DIS							
065 OTHER REIMBURS COST CNTRS							
071 AMBULANCE SERVICES	659,372	13,167	120,395	792,934	161,675	11,013	
093 HOME HEALTH AGENCY							
095 SPEC PURPOSE COST CENTERS							
095 HOSPICE							
098 SUBTOTALS	16,917,740	1,490,001	1,678,898	16,273,764	2,635,414	829,589	74,344
099 NONREIMBURS COST CENTERS							
099 PHYSICIANS' PRIVATE OFFIC	2,782,909	136,373	471,464	3,390,746	691,351	114,060	
099 01 NONPAID WORKERS							
099 02 FOUNDATION	57,120		11,483	68,603	13,988		
100 OCCUPATIONAL MEDICINE	12,906	3,606	997	17,509	3,570	3,016	
101 OTHER NONREIMBURSABLE COS		20,053		20,053	4,089	16,772	
102 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	19,770,675	1,650,033	2,162,842	19,770,675	3,348,412	963,437	74,344

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN	CENTRAL SERVI	PHARMACY	MEDICAL RECOR
	10	11	12	14	15	16	17
003 GENERAL SERVICE COST CNTR							
005 NEW CAP REL COSTS-BLDG &							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE							
011 HOUSEKEEPING	565,067						
012 DIETARY	32,916	389,541					
014 CAFETERIA	10,929		383,938				
015 NURSING ADMINISTRATION	5,275		2,483	102,382			
016 CENTRAL SERVICES & SUPPLY	23,383		4,967		234,713		
017 PHARMACY						628	545,962
025 MEDICAL RECORDS & LIBRARY	16,890		18,377				
026 INPAT ROUTINE SRVC CNTRS							
031 ADULTS & PEDIATRICS	73,355	389,541	52,649	31,816	13,067		234,578
033 INTENSIVE CARE UNIT							
037 SUBPROVIDER							
038 NURSERY							
039 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM	57,506		12,914	7,788	14,171		51,589
041 RECOVERY ROOM	7,392		2,483	1,462	1,072		
042 DELIVERY ROOM & LABOR ROO							
043 ANESTHESIOLOGY						36	
044 RADIOLOGY-DIAGNOSTIC	82,642		39,487		11,592		62,462
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY	24,613		33,278		99,766		
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	1,549		6,705	3,993	985		1,157
050 PHYSICAL THERAPY	43,230		16,887		2,227		
051 OCCUPATIONAL THERAPY	13,081		7,202		143		
052 SPEECH PATHOLOGY	237						
053 ELECTROCARDIOLOGY	4,755		2,235		766		
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED					33,874		
056 30 IMPL. DEV. CHARGED TO PAT					16,574		
060 DRUGS CHARGED TO PATIENTS	4,211		10,430	938	2,234		
061 OUTPAT SERVICE COST CNTRS							
062 CLINIC	30,764		7,450		2,721		
061 EMERGENCY	44,283		44,950	27,165	16,590		196,176
062 01 EMERGENCY PHYSICIAN							
065 OBSERVATION BEDS (NON-DIS							
071 OTHER REIMBURS COST CNTRS							
093 AMBULANCE SERVICES	6,694		48,427	29,220	6,967		
095 HOME HEALTH AGENCY							
099 SPEC PURPOSE COST CENTERS							
099 HOSPICE							
098 SUBTOTALS	483,705	389,541	310,924	102,382	223,413		545,962
099 NONREIMBURS COST CENTERS							
099 PHYSICIANS' PRIVATE OFFIC	69,334		72,766		10,918		
099 NONPAID WORKERS							
099 01 FOUNDATION			248		128		
100 02 OCCUPATIONAL MEDICINE	1,833				254		
101 OTHER NONREIMBURSABLE COS	10,195						
102 CROSS FOOT ADJUSTMENT							
103 NEGATIVE COST CENTER							
103 TOTAL	565,067	389,541	383,938	102,382	234,713		545,962

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART I

	COST CENTER DESCRIPTION	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
		25	26	27
003	GENERAL SERVICE COST CNTR			
005	NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS			
006	ADMINISTRATIVE & GENERAL OPERATION OF PLANT			
008	LAUNDRY & LINEN SERVICE			
009	HOUSEKEEPING			
010	DIETARY			
011	CAFETERIA			
012	NURSING ADMINISTRATION			
014	CENTRAL SERVICES & SUPPLY			
015	PHARMACY			
016	MEDICAL RECORDS & LIBRARY			
017	INPAT ROUTINE SRVC CNTRS			
025	ADULTS & PEDIATRICS	2,468,774		2,468,774
026	INTENSIVE CARE UNIT			
031	SUBPROVIDER			
033	NURSERY			
	ANCILLARY SRVC COST CNTRS			
037	OPERATING ROOM	867,695		867,695
038	RECOVERY ROOM	94,542		94,542
039	DELIVERY ROOM & LABOR ROO			
040	ANESTHESIOLOGY	36		36
041	RADIOLOGY-DIAGNOSTIC	2,210,147		2,210,147
042	RADIOLOGY-THERAPEUTIC			
043	RADIOISOTOPE			
044	LABORATORY	1,917,606		1,917,606
045	PBP CLINICAL LAB SERVICES			
046	WHOLE BLOOD & PACKED RED			
047	BLOOD STORING, PROCESSING			
048	INTRAVENOUS THERAPY			
049	RESPIRATORY THERAPY	221,536		221,536
050	PHYSICAL THERAPY	826,612		826,612
051	OCCUPATIONAL THERAPY	386,040		386,040
052	SPEECH PATHOLOGY	4,801		4,801
053	ELECTROCARDIOLOGY	321,473		321,473
054	ELECTROENCEPHALOGRAPHY			
055	MEDICAL SUPPLIES CHARGED	184,543		184,543
055	30 IMPL. DEV. CHARGED TO PAT	92,294		92,294
056	DRUGS CHARGED TO PATIENTS	1,953,172		1,953,172
	OUTPAT SERVICE COST CNTRS			
060	CLINIC	299,003		299,003
061	EMERGENCY	2,356,038		2,356,038
061	01 EMERGENCY PHYSICIAN			
062	OBSERVATION BEDS (NON-DIS			
	OTHER REIMBURS COST CNTRS			
065	AMBULANCE SERVICES	1,056,930		1,056,930
071	HOME HEALTH AGENCY			
	SPEC PURPOSE COST CENTERS			
093	HOSPICE			
095	SUBTOTALS	15,261,242		15,261,242
	NONREIMBURS COST CENTERS			
098	PHYSICIANS' PRIVATE OFFIC	4,349,175		4,349,175
099	NONPAID WORKERS			
099	01 FOUNDATION	82,967		82,967
099	02 OCCUPATIONAL MEDICINE	26,182		26,182
100	OTHER NONREIMBURSABLE COS	51,109		51,109
101	CROSS FOOT ADJUSTMENT			
102	NEGATIVE COST CENTER			
103	TOTAL	19,770,675		19,770,675

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	DIR ASSIGNED NEW CAPITAL REL COSTS 0	NEW CAP REL C OSTS-BLDG & 3	SUBTOTAL 4a	EMPLOYEE BENE FITS 5	ADMINISTRATIV E & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LIN EN SERVICE 9
003 GENERAL SERVICE COST CNTR							
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS		15,517	15,517	15,517			
006 ADMINISTRATIVE & GENERAL		319,993	319,993	2,874	322,867		
008 OPERATION OF PLANT		162,614	162,614	276	15,733	178,623	
009 LAUNDRY & LINEN SERVICE		6,886	6,886		1,120	1,068	9,074
010 HOUSEKEEPING		33,593	33,593	350	8,684	5,209	637
011 DIETARY		64,743	64,743	137	4,905	10,040	261
012 CAFETERIA		21,496	21,496	341	5,798	3,333	
014 NURSING ADMINISTRATION		10,376	10,376	73	1,404	1,609	
015 CENTRAL SERVICES & SUPPLY		45,993	45,993	68	2,742	7,132	
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY		33,221	33,221	348	7,876	5,151	
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		144,282	144,282	1,273	24,571	22,373	5,916
026 INTENSIVE CARE UNIT							
031 SUBPROVIDER							
033 NURSERY							
037 ANCILLARY SRVC COST CNTRS OPERATING ROOM		113,109	113,109	390	10,194	17,539	594
038 RECOVERY ROOM		14,540	14,540	49	1,143	2,255	
039 DELIVERY ROOM & LABOR ROO							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC		162,544	162,544	1,210	30,617	25,206	384
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY		48,412	48,412	808	28,079	7,507	
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY		3,048	3,048	196	3,331	473	76
050 PHYSICAL THERAPY		85,029	85,029	472	11,295	13,185	179
051 OCCUPATIONAL THERAPY		25,730	25,730	318	5,608	3,990	82
052 SPEECH PATHOLOGY		465	465	4	68	72	4
053 ELECTROCARDIOLOGY		9,352	9,352	296	4,995	1,450	
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED					2,460		
055 30 IMPL. DEV. CHARGED TO PAT					1,237		
056 DRUGS CHARGED TO PATIENTS		8,282	8,282	371	31,492	1,284	
060 OUTPAT SERVICE COST CNTRS CLINIC		60,509	60,509	115	3,388	9,383	
061 EMERGENCY		87,100	87,100	1,213	31,784	13,506	941
061 01 EMERGENCY PHYSICIAN							
062 OBSERVATION BEDS (NON-DIS							
065 OTHER REIMBURS COST CNTRS		13,167	13,167	864	15,589	2,042	
071 AMBULANCE SERVICES HOME HEALTH AGENCY							
093 SPEC PURPOSE COST CENTERS HOSPICE							
095 SUBTOTALS		1,490,001	1,490,001	12,046	254,113	153,807	9,074
098 NONREIMBURS COST CENTERS PHYSICIANS' PRIVATE OFFIC		136,373	136,373	3,382	66,667	21,147	
099 NONPAID WORKERS							
099 01 FOUNDATION				82	1,349		
099 02 OCCUPATIONAL MEDICINE		3,606	3,606	7	344	559	
100 OTHER NONREIMBURSABLE COS		20,053	20,053		394	3,110	
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		1,650,033	1,650,033	15,517	322,867	178,623	9,074

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART III

COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY
	10	11	12	14	15	16	17
003 GENERAL SERVICE COST CNTR							
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING	48,473						
011 DIETARY	2,824	82,910					
012 CAFETERIA	937		31,905				
014 NURSING ADMINISTRATION	453		206	14,121			
015 CENTRAL SERVICES & SUPPLY	2,006		413		58,354		
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY	1,449		1,527		156		49,728
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	6,293	82,910	4,375	4,388	3,249		21,367
031 INTENSIVE CARE UNIT							
033 SUBPROVIDER							
037 NURSERY							
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM	4,933		1,073	1,074	3,523		4,699
039 RECOVERY ROOM	634		206	202	266		
040 DELIVERY ROOM & LABOR ROO							
041 ANESTHESIOLOGY					9		
042 RADIOLOGY-DIAGNOSTIC	7,089		3,281		2,882		5,689
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
044 LABORATORY	2,111		2,765		24,802		
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	133		557	551	245		105
050 PHYSICAL THERAPY	3,708		1,403		554		
051 OCCUPATIONAL THERAPY	1,122		598		36		
052 SPEECH PATHOLOGY	20						
053 ELECTROCARDIOLOGY	408		186		191		
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED					8,422		
056 30 IMPL. DEV. CHARGED TO PAT					4,121		
060 DRUGS CHARGED TO PATIENTS	361		867	129	555		
061 OUTPAT SERVICE COST CNTRS							
061 CLINIC	2,639		619		677		
062 EMERGENCY	3,799		3,735	3,747	4,125		17,868
065 01 EMERGENCY PHYSICIAN							
062 OBSERVATION BEDS (NON-DIS							
062 OTHER REIMBURS COST CNTRS							
071 AMBULANCE SERVICES	574		4,024	4,030	1,732		
093 HOME HEALTH AGENCY							
095 SPEC PURPOSE COST CENTERS							
095 HOSPICE							
095 SUBTOTALS	41,493	82,910	25,835	14,121	55,545		49,728
098 NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC	5,948		6,049		2,714		
099 NONPAID WORKERS							
099 01 FOUNDATION			21		32		
099 02 OCCUPATIONAL MEDICINE	157				63		
100 OTHER NONREIMBURSABLE COS	875						
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	48,473	82,910	31,905	14,121	58,354		49,728

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART III

COST CENTER DESCRIPTION	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	25	26	27
003 GENERAL SERVICE COST CNTR			
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS			
006 ADMINISTRATIVE & GENERAL			
008 OPERATION OF PLANT			
009 LAUNDRY & LINEN SERVICE			
010 HOUSEKEEPING			
011 DIETARY			
012 CAFETERIA			
014 NURSING ADMINISTRATION			
015 CENTRAL SERVICES & SUPPLY			
016 PHARMACY			
017 MEDICAL RECORDS & LIBRARY			
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	320,997		320,997
026 INTENSIVE CARE UNIT			
031 SUBPROVIDER			
033 NURSERY			
037 ANCILLARY SRVC COST CNTRS OPERATING ROOM	157,128		157,128
038 RECOVERY ROOM	19,295		19,295
039 DELIVERY ROOM & LABOR ROO			
040 ANESTHESIOLOGY	9		9
041 RADIOLOGY-DIAGNOSTIC	238,902		238,902
042 RADIOLOGY-THERAPEUTIC			
043 RADIOISOTOPE			
044 LABORATORY	114,484		114,484
045 PBP CLINICAL LAB SERVICES			
046 WHOLE BLOOD & PACKED RED			
047 BLOOD STORING, PROCESSING			
048 INTRAVENOUS THERAPY			
049 RESPIRATORY THERAPY	8,715		8,715
050 PHYSICAL THERAPY	115,825		115,825
051 OCCUPATIONAL THERAPY	37,484		37,484
052 SPEECH PATHOLOGY	633		633
053 ELECTROCARDIOLOGY	16,878		16,878
054 ELECTROENCEPHALOGRAPHY			
055 MEDICAL SUPPLIES CHARGED	10,882		10,882
055 30 IMPL. DEV. CHARGED TO PAT	5,358		5,358
056 DRUGS CHARGED TO PATIENTS	43,341		43,341
060 OUTPAT SERVICE COST CNTRS CLINIC	77,330		77,330
061 EMERGENCY	167,818		167,818
061 01 EMERGENCY PHYSICIAN			
062 OBSERVATION BEDS (NON-DIS			
065 OTHER REIMBURS COST CNTRS	42,022		42,022
071 AMBULANCE SERVICES			
093 HOME HEALTH AGENCY			
095 HOSPICE			
095 SUBTOTALS	1,377,101		1,377,101
098 NONREIMBURS COST CENTERS			
099 PHYSICIANS' PRIVATE OFFIC	242,280		242,280
099 NONPAID WORKERS			
099 01 FOUNDATION	1,484		1,484
099 02 OCCUPATIONAL MEDICINE	4,736		4,736
100 OTHER NONREIMBURSABLE COS	24,432		24,432
101 CROSS FOOT ADJUSTMENTS			
102 NEGATIVE COST CENTER			
103 TOTAL	1,650,033		1,650,033

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

	COST CENTER DESCRIPTION	NEW CAP REL	C	EMPLOYEE BENE	RECONCILIATION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE
		OSTS-BLDG & FITS		FITS		(ACCUM. COST)	(SQUARE FEET)	F(POUNDS OF) LAUNDRY
		(SQUARE FEET)		(GROSS SALARIES)		(ACCUM. COST)	(SQUARE FEET)	F(POUNDS OF) LAUNDRY
		3		5	6a.00	6	8	9
	GENERAL SERVICE COST							
003	NEW CAP REL COSTS-BLD	70,927						
005	EMPLOYEE BENEFITS	667		10,478,483				
006	ADMINISTRATIVE & GENE	13,755		1,940,412	-3,348,412	16,422,263		
008	OPERATION OF PLANT	6,990		186,524		800,267	49,515	
009	LAUNDRY & LINEN SERVI	296				56,969	296	28,495
010	HOUSEKEEPING	1,444		236,448		441,693	1,444	2,000
011	DIETARY	2,783		92,533		249,470	2,783	820
012	CAFETERIA	924		230,248		294,901	924	
014	NURSING ADMINISTRATIO	446		49,597		71,390	446	
015	CENTRAL SERVICES & SU	1,977		46,170		139,461	1,977	
016	PHARMACY							
017	MEDICAL RECORDS & LIB	1,428		234,963		400,601	1,428	
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	6,202		859,406		1,249,792	6,202	18,580
026	INTENSIVE CARE UNIT							
031	SUBPROVIDER							
033	NURSERY							
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	4,862		263,040		518,533	4,862	1,865
038	RECOVERY ROOM	625		33,196		58,121	625	
039	DELIVERY ROOM & LABOR							
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC	6,987		817,044		1,557,337	6,987	1,205
042	RADIOLOGY-THERAPEUTIC							
043	RADIOISOTOPE							
044	LABORATORY	2,081		545,500		1,428,246	2,081	
045	PBP CLINICAL LAB SERV							
046	WHOLE BLOOD & PACKED							
047	BLOOD STORING, PROCES							
048	INTRAVENOUS THERAPY							
049	RESPIRATORY THERAPY	131		132,506		169,427	131	240
050	PHYSICAL THERAPY	3,655		318,679		574,541	3,655	561
051	OCCUPATIONAL THERAPY	1,106		214,639		285,258	1,106	258
052	SPEECH PATHOLOGY	20		2,469		3,444	20	11
053	ELECTROCARDIOLOGY	402		200,137		254,088	402	
054	ELECTROENCEPHALOGRAPH							
055	MEDICAL SUPPLIES CHAR					125,151		
055	30 IMPL. DEV. CHARGED TO					62,896		
056	DRUGS CHARGED TO PATI	356		250,399		1,601,827	356	
	OUTPAT SERVICE COST C							
060	CLINIC	2,601		77,528		172,323	2,601	
061	EMERGENCY	3,744		819,153		1,616,682	3,744	2,955
061	01 EMERGENCY PHYSICIAN							
062	OBSERVATION BEDS (NON							
	OTHER REIMBURS COST C							
065	AMBULANCE SERVICES	566		583,288		792,934	566	
071	HOME HEALTH AGENCY							
	SPEC PURPOSE COST CEN							
093	HOSPICE							
095	SUBTOTALS	64,048		8,133,879	-3,348,412	12,925,352	42,636	28,495
	NONREIMBURS COST CENT							
098	PHYSICIANS' PRIVATE O	5,862		2,284,143		3,390,746	5,862	
099	NONPAID WORKERS							
099	01 FOUNDATION			55,631		68,603		
099	02 OCCUPATIONAL MEDICINE	155		4,830		17,509	155	
100	OTHER NONREIMBURSABLE	862				20,053	862	
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED	1,650,033		2,162,842		3,348,412	963,437	74,344
	(WRKSHT B, PART I)							
104	UNIT COST MULTIPLIER	23.263821					19.457478	
	(WRKSHT B, PT I)			.206408		.203895		2.609019
105	COST TO BE ALLOCATED							
	(WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER							
	(WRKSHT B, PT II)							
107	COST TO BE ALLOCATED			15,517		322,867	178,623	9,074
	(WRKSHT B, PART III)							
108	UNIT COST MULTIPLIER						3.607452	
	(WRKSHT B, PT III)			.001481		.019660		.318442

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

	COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY
		(SQUARE FEET)	(MEALS SERVED)	(FTE'S)	(DIRECT NURSING HRS)	NR(COSTED)EQUIS.	R(COSTED)EQUIS.	R(TIME)SPENT
	GENERAL SERVICE COST	10	11	12	14	15	16	17
003	NEW CAP REL COSTS-BLD							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE							
008	OPERATION OF PLANT							
009	LAUNDRY & LINEN SERVI							
010	HOUSEKEEPING	47,775						
011	DIETARY	2,783	100					
012	CAFETERIA	924		1,546				
014	NURSING ADMINISTRATIO	446		10	142,047			
015	CENTRAL SERVICES & SU	1,977		20		772,977		
016	PHARMACY						100	
017	MEDICAL RECORDS & LIB	1,428		74		2,069		94,400
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	6,202	100	212	44,142	43,032		40,560
026	INTENSIVE CARE UNIT							
031	SUBPROVIDER							
033	NURSERY							
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	4,862		52	10,805	46,669		8,920
038	RECOVERY ROOM	625		10	2,029	3,529		
039	DELIVERY ROOM & LABOR							
040	ANESTHESIOLOGY					120		
041	RADIOLOGY-DIAGNOSTIC	6,987		159		38,176		10,800
042	RADIOLOGY-THERAPEUTIC							
043	RADIOISOTOPE							
044	LABORATORY	2,081		134		328,554		
045	PBP CLINICAL LAB SERV							
046	WHOLE BLOOD & PACKED							
047	BLOOD STORING, PROCES							
048	INTRAVENOUS THERAPY							
049	RESPIRATORY THERAPY	131		27	5,540	3,243		200
050	PHYSICAL THERAPY	3,655		68		7,334		
051	OCCUPATIONAL THERAPY	1,106		29		471		
052	SPEECH PATHOLOGY	20						
053	ELECTROCARDIOLOGY	402		9		2,524		
054	ELECTROENCEPHALOGRAPH							
055	MEDICAL SUPPLIES CHAR					111,558		
055	30 IMPL. DEV. CHARGED TO					54,583		
056	DRUGS CHARGED TO PATI	356		42	1,301	7,357	100	
	OUTPAT SERVICE COST C							
060	CLINIC	2,601		30		8,962		
061	EMERGENCY	3,744		181	37,689	54,637		33,920
061	01 EMERGENCY PHYSICIAN							
062	OBSERVATION BEDS (NON							
	OTHER REIMBURS COST C							
065	AMBULANCE SERVICES	566		195	40,541	22,945		
071	HOME HEALTH AGENCY							
	SPEC PURPOSE COST CEN							
093	HOSPICE							
095	SUBTOTALS	40,896	100	1,252	142,047	735,763	100	94,400
	NONREIMBURS COST CENT							
098	PHYSICIANS' PRIVATE O	5,862		293		35,955		
099	NONPAID WORKERS							
099	01 FOUNDATION			1		421		
099	02 OCCUPATIONAL MEDICINE	155				838		
100	OTHER NONREIMBURSABLE	862						
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED	565,067	389,541	383,938	102,382	234,713		545,962
	(WRKSHT B, PART I)							
104	UNIT COST MULTIPLIER		3,895.410000		.720761			
	(WRKSHT B, PT I)	11.827671		248.342820		.303648		5.783496
105	COST TO BE ALLOCATED							
	(WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER							
	(WRKSHT B, PT II)							
107	COST TO BE ALLOCATED	48,473	82,910	31,905	14,121	58,354		49,728
	(WRKSHT B, PART III)							
108	UNIT COST MULTIPLIER		829.100000		.099411			
	(WRKSHT B, PT III)	1.014610		20.637128		.075493		.526780

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET C
 I I TO 12/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27	THERAPY ADJUSTMENT	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS
		1	2	3	4	5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	2,468,774		2,468,774		
26	INTENSIVE CARE UNIT					
31	SUBPROVIDER					
33	NURSERY					
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	867,695		867,695		
38	RECOVERY ROOM	94,542		94,542		
39	DELIVERY ROOM & LABOR ROO					
40	ANESTHESIOLOGY	36		36		
41	RADIOLOGY-DIAGNOSTIC	2,210,147		2,210,147		
42	RADIOLOGY-THERAPEUTIC					
43	RADIOISOTOPE					
44	LABORATORY	1,917,606		1,917,606		
45	PBP CLINICAL LAB SERVICES					
46	WHOLE BLOOD & PACKED RED					
47	BLOOD STORING, PROCESSING					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	221,536		221,536		
50	PHYSICAL THERAPY	826,612		826,612		
51	OCCUPATIONAL THERAPY	386,040		386,040		
52	SPEECH PATHOLOGY	4,801		4,801		
53	ELECTROCARDIOLOGY	321,473		321,473		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	184,543		184,543		
55	30 IMPL. DEV. CHARGED TO PAT	92,294		92,294		
56	DRUGS CHARGED TO PATIENTS	1,953,172		1,953,172		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	299,003		299,003		
61	EMERGENCY	2,356,038		2,356,038		
61	01 EMERGENCY PHYSICIAN					
62	OBSERVATION BEDS (NON-DIS	464,000		464,000		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	1,056,930		1,056,930		
101	SUBTOTAL	15,725,242		15,725,242		
102	LESS OBSERVATION BEDS	464,000		464,000		
103	TOTAL	15,261,242		15,261,242		

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET C
 I I TO 12/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	2,214,900		2,214,900			
26	INTENSIVE CARE UNIT						
31	SUBPROVIDER						
33	NURSERY						
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	72,881	1,815,216	1,888,097	.459561	.459561	
38	RECOVERY ROOM	9,930	390,167	400,097	.236298	.236298	
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	527,517	11,778,045	12,305,562	.179606	.179606	
42	RADIOLOGY-THERAPEUTIC						
43	RADIOISOTOPE						
44	LABORATORY	630,041	7,430,839	8,060,880	.237890	.237890	
45	PBP CLINICAL LAB SERVICES						
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	296,181	238,921	535,102	.414007	.414007	
50	PHYSICAL THERAPY	227,733	1,412,033	1,639,766	.504104	.504104	
51	OCCUPATIONAL THERAPY	119,748	564,032	683,780	.564568	.564568	
52	SPEECH PATHOLOGY	2,307	9,990	12,297	.390420	.390420	
53	ELECTROCARDIOLOGY	119,918	1,601,307	1,721,225	.186770	.186770	
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	121,129	1,585,859	1,706,988	.108110	.108110	
55	30 IMPL. DEV. CHARGED TO PAT	200	193,269	193,469	.477048	.477048	
56	DRUGS CHARGED TO PATIENTS	909,559	3,828,823	4,738,382	.412202	.412202	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	55,684	3,613,415	3,669,099	.642130	.642130	
61	01 EMERGENCY PHYSICIAN						
62	OBSERVATION BEDS (NON-DIS		507,543	507,543	.914208	.914208	
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		958,252	958,252	1.102977	1.102977	
101	SUBTOTAL	5,307,728	35,927,711	41,235,439			
102	LESS OBSERVATION BEDS						
103	TOTAL	5,307,728	35,927,711	41,235,439			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
I 15-1304 I FROM 1/ 1/2010 I WORKSHEET C
I I TO 12/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	2,468,774		2,468,774		
26	INTENSIVE CARE UNIT					
31	SUBPROVIDER					
33	NURSERY					
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	867,695		867,695		
38	RECOVERY ROOM	94,542		94,542		
39	DELIVERY ROOM & LABOR ROO					
40	ANESTHESIOLOGY	36		36		
41	RADIOLOGY-DIAGNOSTIC	2,210,147		2,210,147		
42	RADIOLOGY-THERAPEUTIC					
43	RADIOISOTOPE					
44	LABORATORY	1,917,606		1,917,606		
45	PBP CLINICAL LAB SERVICES					
46	WHOLE BLOOD & PACKED RED					
47	BLOOD STORING, PROCESSING					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	221,536		221,536		
50	PHYSICAL THERAPY	826,612		826,612		
51	OCCUPATIONAL THERAPY	386,040		386,040		
52	SPEECH PATHOLOGY	4,801		4,801		
53	ELECTROCARDIOLOGY	321,473		321,473		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	184,543		184,543		
55	30 IMPL. DEV. CHARGED TO PAT	92,294		92,294		
56	DRUGS CHARGED TO PATIENTS	1,953,172		1,953,172		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	299,003		299,003		
61	EMERGENCY	2,356,038		2,356,038		
61	01 EMERGENCY PHYSICIAN					
62	OBSERVATION BEDS (NON-DIS	464,000		464,000		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	1,056,930		1,056,930		
101	SUBTOTAL	15,725,242		15,725,242		
102	LESS OBSERVATION BEDS	464,000		464,000		
103	TOTAL	15,261,242		15,261,242		

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
I 15-1304 I FROM 1/ 1/2010 I WORKSHEET C
I I TO 12/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	2,214,900		2,214,900			
26	INTENSIVE CARE UNIT						
31	SUBPROVIDER						
33	NURSERY						
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	72,881	1,815,216	1,888,097	.459561	.459561	
38	RECOVERY ROOM	9,930	390,167	400,097	.236298	.236298	
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	527,517	11,778,045	12,305,562	.179606	.179606	
42	RADIOLOGY-THERAPEUTIC						
43	RADIOISOTOPE						
44	LABORATORY	630,041	7,430,839	8,060,880	.237890	.237890	
45	PBP CLINICAL LAB SERVICES						
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	296,181	238,921	535,102	.414007	.414007	
50	PHYSICAL THERAPY	227,733	1,412,033	1,639,766	.504104	.504104	
51	OCCUPATIONAL THERAPY	119,748	564,032	683,780	.564568	.564568	
52	SPEECH PATHOLOGY	2,307	9,990	12,297	.390420	.390420	
53	ELECTROCARDIOLOGY	119,918	1,601,307	1,721,225	.186770	.186770	
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	121,129	1,585,859	1,706,988	.108110	.108110	
55	30 IMPL. DEV. CHARGED TO PAT	200	193,269	193,469	.477048	.477048	
56	DRUGS CHARGED TO PATIENTS	909,559	3,828,823	4,738,382	.412202	.412202	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	55,684	3,613,415	3,669,099	.642130	.642130	
61	01 EMERGENCY PHYSICIAN						
62	OBSERVATION BEDS (NON-DIS		507,543	507,543	.914208	.914208	
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		958,252	958,252	1.102977	1.102977	
101	SUBTOTAL	5,307,728	35,927,711	41,235,439			
102	LESS OBSERVATION BEDS						
103	TOTAL	5,307,728	35,927,711	41,235,439			

Health Financial Systems MCRIF32 FOR RUSH MEMORIAL HOSPITAL
 CALCULATION OF OUTPATIENT SERVICE COST TO
 CHARGE RATIOS NET OF REDUCTIONS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET C
 I I TO 12/31/2010 I PART II

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	867,695	157,128	710,567			867,695
38	RECOVERY ROOM	94,542	19,295	75,247			94,542
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY	36	9	27			36
41	RADIOLOGY-DIAGNOSTIC	2,210,147	238,902	1,971,245			2,210,147
42	RADIOLOGY-THERAPEUTIC						
43	RADIOISOTOPE						
44	LABORATORY	1,917,606	114,484	1,803,122			1,917,606
45	PBP CLINICAL LAB SERVICES						
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	221,536	8,715	212,821			221,536
50	PHYSICAL THERAPY	826,612	115,825	710,787			826,612
51	OCCUPATIONAL THERAPY	386,040	37,484	348,556			386,040
52	SPEECH PATHOLOGY	4,801	633	4,168			4,801
53	ELECTROCARDIOLOGY	321,473	16,878	304,595			321,473
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	184,543	10,882	173,661			184,543
55	30 IMPL. DEV. CHARGED TO PAT	92,294	5,358	86,936			92,294
56	DRUGS CHARGED TO PATIENTS	1,953,172	43,341	1,909,831			1,953,172
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	299,003	77,330	221,673			299,003
61	EMERGENCY	2,356,038	167,818	2,188,220			2,356,038
61	01 EMERGENCY PHYSICIAN						
62	OBSERVATION BEDS (NON-DIS	464,000		464,000			464,000
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	1,056,930	42,022	1,014,908			1,056,930
101	SUBTOTAL	13,256,468	1,056,104	12,200,364			13,256,468
102	LESS OBSERVATION BEDS	464,000		464,000			464,000
103	TOTAL	12,792,468	1,056,104	11,736,364			12,792,468

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	1,888,097	.459561	.459561
38	RECOVERY ROOM	400,097	.236298	.236298
39	DELIVERY ROOM & LABOR ROO			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	12,305,562	.179606	.179606
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	8,060,880	.237890	.237890
45	PBP CLINICAL LAB SERVICES			
46	WHOLE BLOOD & PACKED RED			
47	BLOOD STORING, PROCESSING			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	535,102	.414007	.414007
50	PHYSICAL THERAPY	1,639,766	.504104	.504104
51	OCCUPATIONAL THERAPY	683,780	.564568	.564568
52	SPEECH PATHOLOGY	12,297	.390420	.390420
53	ELECTROCARDIOLOGY	1,721,225	.186770	.186770
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	1,706,988	.108110	.108110
55	30 IMPL. DEV. CHARGED TO PAT	193,469	.477048	.477048
56	DRUGS CHARGED TO PATIENTS	4,738,382	.412202	.412202
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	3,669,099	.642130	.642130
61	01 EMERGENCY PHYSICIAN			
62	OBSERVATION BEDS (NON-DIS	507,543	.914208	.914208
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	958,252	1.102977	1.102977
101	SUBTOTAL	39,020,539		
102	LESS OBSERVATION BEDS	507,543		
103	TOTAL	38,512,996		

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	867,695	157,128	710,567			867,695
38	RECOVERY ROOM	94,542	19,295	75,247			94,542
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY	36	9	27			36
41	RADIOLOGY-DIAGNOSTIC	2,210,147	238,902	1,971,245			2,210,147
42	RADIOLOGY-THERAPEUTIC						
43	RADIOISOTOPE						
44	LABORATORY	1,917,606	114,484	1,803,122			1,917,606
45	PBP CLINICAL LAB SERVICES						
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	221,536	8,715	212,821			221,536
50	PHYSICAL THERAPY	826,612	115,825	710,787			826,612
51	OCCUPATIONAL THERAPY	386,040	37,484	348,556			386,040
52	SPEECH PATHOLOGY	4,801	633	4,168			4,801
53	ELECTROCARDIOLOGY	321,473	16,878	304,595			321,473
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	184,543	10,882	173,661			184,543
55	30 IMPL. DEV. CHARGED TO PAT	92,294	5,358	86,936			92,294
56	DRUGS CHARGED TO PATIENTS	1,953,172	43,341	1,909,831			1,953,172
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	299,003	77,330	221,673			299,003
61	EMERGENCY	2,356,038	167,818	2,188,220			2,356,038
61	01 EMERGENCY PHYSICIAN						
62	OBSERVATION BEDS (NON-DIS	464,000		464,000			464,000
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	1,056,930	42,022	1,014,908			1,056,930
101	SUBTOTAL	13,256,468	1,056,104	12,200,364			13,256,468
102	LESS OBSERVATION BEDS	464,000		464,000			464,000
103	TOTAL	12,792,468	1,056,104	11,736,364			12,792,468

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	1,888,097	.459561	.459561
38	RECOVERY ROOM	400,097	.236298	.236298
39	DELIVERY ROOM & LABOR ROO			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	12,305,562	.179606	.179606
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	8,060,880	.237890	.237890
45	PBP CLINICAL LAB SERVICES			
46	WHOLE BLOOD & PACKED RED			
47	BLOOD STORING, PROCESSING			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	535,102	.414007	.414007
50	PHYSICAL THERAPY	1,639,766	.504104	.504104
51	OCCUPATIONAL THERAPY	683,780	.564568	.564568
52	SPEECH PATHOLOGY	12,297	.390420	.390420
53	ELECTROCARDIOLOGY	1,721,225	.186770	.186770
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	1,706,988	.108110	.108110
55	30 IMPL. DEV. CHARGED TO PAT	193,469	.477048	.477048
56	DRUGS CHARGED TO PATIENTS	4,738,382	.412202	.412202
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	3,669,099	.642130	.642130
61	01 EMERGENCY PHYSICIAN			
62	OBSERVATION BEDS (NON-DIS	507,543	.914208	.914208
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	958,252	1.102977	1.102977
101	SUBTOTAL	39,020,539		
102	LESS OBSERVATION BEDS	507,543		
103	TOTAL	38,512,996		

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	.459561		.459561		
38	RECOVERY ROOM	.236298		.236298		
39	DELIVERY ROOM & LABOR ROOM					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	.179606		.179606		
42	RADIOLOGY-THERAPEUTIC					
43	RADIOISOTOPE					
44	LABORATORY	.237890		.237890		
45	PBP CLINICAL LAB SERVICES-PRGM ONLY					
46	WHOLE BLOOD & PACKED RED BLOOD CELLS					
47	BLOOD STORING, PROCESSING & TRANS.					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	.414007		.414007		
50	PHYSICAL THERAPY	.504104		.504104		
51	OCCUPATIONAL THERAPY	.564568		.564568		
52	SPEECH PATHOLOGY	.390420		.390420		
53	ELECTROCARDIOLOGY	.186770		.186770		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.108110		.108110		
55	30 IMPL. DEV. CHARGED TO PATIENT	.477048		.477048		
56	DRUGS CHARGED TO PATIENTS	.412202		.412202		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	.642130		.642130		
61	01 EMERGENCY PHYSICIAN					
62	OBSERVATION BEDS (NON-DISTINCT PART)	.914208		.914208		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	1.102977		1.102977		
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII, PART B		HOSPITAL				
		Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
Cost Center Description		4	5	6	7	8
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		916,020			
38	RECOVERY ROOM		94,881			
39	DELIVERY ROOM & LABOR ROOM					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC		3,834,394			
42	RADIOLOGY-THERAPEUTIC					
43	RADIOISOTOPE					
44	LABORATORY		2,388,736			
45	PBP CLINICAL LAB SERVICES-PRGM ONLY					
46	WHOLE BLOOD & PACKED RED BLOOD CELLS					
47	BLOOD STORING, PROCESSING & TRANS.					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY		69,112			
50	PHYSICAL THERAPY		408,076			
51	OCCUPATIONAL THERAPY		173,937			
52	SPEECH PATHOLOGY		3,933			
53	ELECTROCARDIOLOGY		919,826			
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		135,774			
55	30 IMPL. DEV. CHARGED TO PATIENT		51,628			
56	DRUGS CHARGED TO PATIENTS		2,282,015			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY		760,788			
61	01 EMERGENCY PHYSICIAN					
62	OBSERVATION BEDS (NON-DISTINCT PART)		238,522			
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL		12,277,642			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104	NET CHARGES		12,277,642			

(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 Hospital I/P
 Part B Charges Part B Costs

Cost Center	Description	9	10	11
(A)	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	420,967		
38	RECOVERY ROOM	22,420		
39	DELIVERY ROOM & LABOR ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	688,680		
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	568,256		
45	PBP CLINICAL LAB SERVICES-PRGM ONLY			
46	WHOLE BLOOD & PACKED RED BLOOD CELLS			
47	BLOOD STORING, PROCESSING & TRANS.			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	28,613		
50	PHYSICAL THERAPY	205,713		
51	OCCUPATIONAL THERAPY	98,199		
52	SPEECH PATHOLOGY	1,536		
53	ELECTROCARDIOLOGY	171,796		
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,679		
55	30 IMPL. DEV. CHARGED TO PATIENT	24,629		
56	DRUGS CHARGED TO PATIENTS	940,651		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	488,525		
61	01 EMERGENCY PHYSICIAN			
62	OBSERVATION BEDS (NON-DISTINCT PART)	218,059		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	SUBTOTAL	3,892,723		
102	CRNA CHARGES			
103	LESS PBP CLINIC LAB SVCS-			
	PROGRAM ONLY CHARGES			
104	NET CHARGES	3,892,723		

(A) WORKSHEET A LINE NUMBERS

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

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/27/2011
I	15-1304	I	FROM 1/ 1/2010	I	WORKSHEET D
I	COMPONENT NO:	I	TO 12/31/2010	I	PART VI
I	15-1304	I		I	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1	.412202
2	PROGRAM VACCINE CHARGES		105
3	PROGRAM COSTS		43

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)	2,752
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,032
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,032
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	623
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	97
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,016
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	623
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,468,774
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)	579,303
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,889,471

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,214,900
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,214,900
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.853073
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,090.01
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1,889,471

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 929.86
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 944,738
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 944,738

	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)					
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
44 INTENSIVE CARE UNIT					
45 CORONARY CARE UNIT					
46 BURN INTENSIVE CARE UNIT					
47 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					1
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					459,617
49 TOTAL PROGRAM INPATIENT COSTS					1,404,355

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) 579,303
 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 579,303
 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	499
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	929.86
85	OBSERVATION BED COST	464,000

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				

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2010 I PART I
 I 15-1304 I I

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)	2,752
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,032
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,032
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	623
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	97
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)	91
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,468,774
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)	579,303
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,889,471

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,214,900
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,214,900
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.853073
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,090.01
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1,889,471

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 929.86
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 84,617
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 84,617

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					1
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					79,719
49 TOTAL PROGRAM INPATIENT COSTS					164,336

PASS THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2010 I PART III
 I 15-1304 I I

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 499
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 929.86
- 85 OBSERVATION BED COST 464,000

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-1304 I

TITLE XVIII, PART A

HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS			
26	ADULTS & PEDIATRICS		953,399	
31	INTENSIVE CARE UNIT			
	SUBPROVIDER			
37	ANCILLARY SRVC COST CNTRS			
38	OPERATING ROOM	.459561	45,029	20,694
39	RECOVERY ROOM	.236298	3,492	825
40	DELIVERY ROOM & LABOR ROOM			
41	ANESTHESIOLOGY			
42	RADIOLOGY-DIAGNOSTIC	.179606	237,432	42,644
43	RADIOLOGY-THERAPEUTIC			
44	RADIOISOTOPE			
45	LABORATORY	.237890	345,287	82,140
46	PBP CLINICAL LAB SERVICES-PRGM ONLY			
47	WHOLE BLOOD & PACKED RED BLOOD CELLS			
48	BLOOD STORING, PROCESSING & TRANS.			
49	INTRAVENOUS THERAPY			
50	RESPIRATORY THERAPY	.414007	170,094	70,420
51	PHYSICAL THERAPY	.504104	40,901	20,618
52	OCCUPATIONAL THERAPY	.564568	20,129	11,364
53	SPEECH PATHOLOGY	.390420	798	312
54	ELECTROCARDIOLOGY	.186770	76,440	14,277
55	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.108110	34,385	3,717
55	30 IMPL. DEV. CHARGED TO PATIENT	.477048	105	50
56	DRUGS CHARGED TO PATIENTS	.412202	464,974	191,663
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.642130	1,390	893
61	01 EMERGENCY PHYSICIAN			
62	OBSERVATION BEDS (NON-DISTINCT PART)	.914208		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		1,440,456	459,617
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,440,456	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-Z304 I

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			
31	SUBPROVIDER ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.459561	5,078	2,334
38	RECOVERY ROOM	.236298		
39	DELIVERY ROOM & LABOR ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.179606	22,397	4,023
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	.237890	29,600	7,042
45	PBP CLINICAL LAB SERVICES-PRGM ONLY			
46	WHOLE BLOOD & PACKED RED BLOOD CELLS			
47	BLOOD STORING, PROCESSING & TRANS.			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	.414007	47,910	19,835
50	PHYSICAL THERAPY	.504104	150,347	75,791
51	OCCUPATIONAL THERAPY	.564568	80,594	45,501
52	SPEECH PATHOLOGY	.390420	1,509	589
53	ELECTROCARDIOLOGY	.186770	12,645	2,362
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.108110	7,042	761
55	30 IMPL. DEV. CHARGED TO PATIENT	.477048		
56	DRUGS CHARGED TO PATIENTS	.412202	103,615	42,710
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.642130		
61	01 EMERGENCY PHYSICIAN			
62	OBSERVATION BEDS (NON-DISTINCT PART)	.914208		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		460,737	200,948
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		460,737	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-1304 I

TITLE XIX

HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		104,357	
26	INTENSIVE CARE UNIT			
31	SUBPROVIDER ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.459561	19,099	8,777
38	RECOVERY ROOM	.236298	2,701	638
39	DELIVERY ROOM & LABOR ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.179606	50,674	9,101
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	.237890	52,035	12,379
45	PBP CLINICAL LAB SERVICES-PRGM ONLY			
46	WHOLE BLOOD & PACKED RED BLOOD CELLS			
47	BLOOD STORING, PROCESSING & TRANS.			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	.414007	19,365	8,017
50	PHYSICAL THERAPY	.504104	986	497
51	OCCUPATIONAL THERAPY	.564568	656	370
52	SPEECH PATHOLOGY	.390420		
53	ELECTROCARDIOLOGY	.186770	2,647	494
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.108110	16,549	1,789
55	30 IMPL. DEV. CHARGED TO PATIENT	.477048		
56	DRUGS CHARGED TO PATIENTS	.412202	64,312	26,510
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.642130	17,359	11,147
61	01 EMERGENCY PHYSICIAN			
62	OBSERVATION BEDS (NON-DISTINCT PART)	.914208		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		246,383	79,719
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		246,383	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET E
 I COMPONENT NO: I TO 12/31/2010 I PART B
 I 15-1304 I I

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) 3,892,766
 1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1,
 2001 (SEE INSTRUCTIONS).
 1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.
 1.03 ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.
 1.04 LINE 1.01 TIMES LINE 1.03.
 1.05 LINE 1.02 DIVIDED BY LINE 1.04.
 1.06 TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)
 1.07 OUTPATIENT ANCILLARY PASSTHRU COSTS FROM (W/S D,IV
 (COLS 9, 9.01, 9.02) LINE 101
 2 INTERNS AND RESIDENTS
 3 ORGAN ACQUISITIONS
 4 COST OF TEACHING PHYSICIANS
 5 TOTAL COST (SEE INSTRUCTIONS) 3,892,766

COMPUTATION OF LESSER OF COST OR CHARGES

REASONABLE CHARGES
 6 ANCILLARY SERVICE CHARGES
 7 INTERNS AND RESIDENTS SERVICE CHARGES
 8 ORGAN ACQUISITION CHARGES
 9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.
 10 TOTAL REASONABLE CHARGES
 CUSTOMARY CHARGES
 11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR
 PAYMENT FOR SERVICES ON A CHARGE BASIS
 12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE
 FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT
 BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).
 13 RATIO OF LINE 11 TO LINE 12
 14 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)
 15 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST
 16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES
 17 LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC) 3,931,694
 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18 CAH DEDUCTIBLES 22,038
 18.01 CAH ACTUAL BILLED COINSURANCE 1,988,088
 LINE 17.01 (SEE INSTRUCTIONS)
 19 SUBTOTAL (SEE INSTRUCTIONS) 1,921,568
 20 SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)
 21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS
 22 ESRD DIRECT MEDICAL EDUCATION COSTS
 23 SUBTOTAL 1,921,568
 24 PRIMARY PAYER PAYMENTS 292
 25 SUBTOTAL 1,921,276

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26 COMPOSITE RATE ESRD
 27 BAD DEBTS (SEE INSTRUCTIONS) 671,455
 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) 671,455
 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES 506,745
 28 SUBTOTAL 2,592,731
 29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER
 TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.
 30 OTHER ADJUSTMENTS (SPECIFY)
 30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)
 31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING
 FROM DISPOSITION OF DEPRECIABLE ASSETS.
 32 SUBTOTAL 2,592,731
 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)
 34 INTERIM PAYMENTS 2,484,752
 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)
 35 BALANCE DUE PROVIDER/PROGRAM 107,979
 36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)
 IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2

TO BE COMPLETED BY CONTRACTOR

50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)
 51 OUTLIER RECONCILIATION ADJUSTMENT AMOUNT
 (SEE INSTRUCTIONS)
 52 THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY
 53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)
 54 TOTAL (SUM OF LINES 51 AND 53)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-1304 I I

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,333,457		2,239,914
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER	.01 1/ 1/2010	2,936	1/ 1/2010	29,740
ADJUSTMENTS TO PROVIDER	.02 8/12/2010	16,548		
ADJUSTMENTS TO PROVIDER	.03 12/16/2010	34,169	12/16/2010	264,190
ADJUSTMENTS TO PROVIDER	.04			
ADJUSTMENTS TO PROVIDER	.05			
ADJUSTMENTS TO PROVIDER	.49			
ADJUSTMENTS TO PROGRAM	.50		8/12/2010	49,092
ADJUSTMENTS TO PROGRAM	.51			
ADJUSTMENTS TO PROGRAM	.52			
ADJUSTMENTS TO PROGRAM	.53			
ADJUSTMENTS TO PROGRAM	.54			
SUBTOTAL	.99	53,653		244,838
4 TOTAL INTERIM PAYMENTS		1,387,110		2,484,752
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER	.01			
TENTATIVE TO PROVIDER	.02			
TENTATIVE TO PROVIDER	.03			
TENTATIVE TO PROGRAM	.50			
TENTATIVE TO PROGRAM	.51			
TENTATIVE TO PROGRAM	.52			
SUBTOTAL	.99	NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER	.01			107,979
SETTLEMENT TO PROGRAM	.02	154,845		
7 TOTAL MEDICARE PROGRAM LIABILITY		1,232,265		2,592,731

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-Z304 I I

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		854,317		
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	21,160		
ADJUSTMENTS TO PROVIDER .02	12/16/2010	13,340		
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		34,500		NONE
4 TOTAL INTERIM PAYMENTS		888,817		
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL		NONE		NONE
6 DETERMINED NET SETTLEMENT				
AMOUNT (BALANCE DUE)				
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02		104,614		
BASED ON COST REPORT (1)				
7 TOTAL MEDICARE PROGRAM LIABILITY		784,203		

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 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I
 I COMPONENT NO: I TO 12/31/2010 I WORKSHEET E-2
 I 15-Z304 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)	585,096	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	202,957	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	623	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	788,053	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	788,053	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	788,053	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	3,850	
14	80% OF PART B COSTS		
15	SUBTOTAL	784,203	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	784,203	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	888,817	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	-104,614	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/27/2011
I	15-1304	I	FROM 1/ 1/2010	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 12/31/2010	I	PART II
I	15-1304	I		I	

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	1,404,355
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	1,404,355
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	1,418,399

COMPUTATION OF LESSER OF COST OR CHARGES

7	REASONABLE CHARGES	
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
12	CUSTOMARY CHARGES	
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	1,418,399
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	261,700
21	EXCESS REASONABLE COST	
22	SUBTOTAL	1,156,699
23	COINSURANCE	550
24	SUBTOTAL	1,156,149
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	76,116
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	76,116
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	58,901
26	SUBTOTAL	1,232,265
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	1,232,265
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	1,387,110
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	-154,845
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET E-3
 I COMPONENT NO: I TO 12/31/2010 I PART III
 I - I I

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

	TITLE XIX	HOSPITAL	OTHER TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
	COMPUTATION OF NET COST OF COVERED SERVICE			
1	INPATIENT HOSPITAL/SNF/NF SERVICES		164,336	
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		164,336	
7	INPATIENT PRIMARY PAYER PAYMENTS			
8	OUTPATIENT PRIMARY PAYER PAYMENTS			
9	SUBTOTAL		164,336	
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
10	ROUTINE SERVICE CHARGES		104,357	
11	ANCILLARY SERVICE CHARGES		246,383	
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		350,740	
	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)		350,740	
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		186,404	
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
23	COST OF COVERED SERVICES		164,336	
	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		164,336	
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		164,336	
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34	EXCESS OF REASONABLE COST			
35	SUBTOTAL		164,336	
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)		164,336	
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		164,336	
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER		164,336	
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
57	INTERIM PAYMENTS		93,126	
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/27/2011
I	15-1304	I	FROM 1/ 1/2010	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 12/31/2010	I	PART III
I	-	I		I	

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

	TITLE XIX	HOSPITAL	OTHER TITLE V OR TITLE XIX	TITLE XVIII SNF PPS
58	BALANCE DUE PROVIDER/PROGRAM		1	2
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		71,210	

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I
 I I TO 12/31/2010 I WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC FUND PURPOSE	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	2,139,386			
2	TEMPORARY INVESTMENTS	14,150			
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	7,344,654			
5	OTHER RECEIVABLES				
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-3,198,560			
7	INVENTORY	555,398			
8	PREPAID EXPENSES	146,934			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS	76,229			
11	TOTAL CURRENT ASSETS	7,078,191			
FIXED ASSETS					
12	LAND	164,978			
12.01					
13	LAND IMPROVEMENTS	235,799			
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	12,000,218			
14.01	LESS ACCUMULATED DEPRECIATION	-16,030			
15	LEASEHOLD IMPROVEMENTS	57,726			
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT	685,390			
16.01	LESS ACCUMULATED DEPRECIATION	-2,920			
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT	10,515,923			
18.01	LESS ACCUMULATED DEPRECIATION	-13,959,586			
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	9,681,498			
OTHER ASSETS					
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS				
26	TOTAL OTHER ASSETS				
27	TOTAL ASSETS	16,759,689			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	716,188			
29 SALARIES, WAGES & FEES PAYABLE	1,427,980			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	994,355			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	750,964			
36 TOTAL CURRENT LIABILITIES	3,889,487			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	3,368,513			
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	3,368,513			
43 TOTAL LIABILITIES	7,258,000			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	9,501,689			
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	9,501,689			
52 TOTAL LIABILITIES AND FUND BALANCES	16,759,689			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING		9,521,926		
2 OF PERIOD				
2 NET INCOME (LOSS)		31,534		
3 TOTAL		9,553,460		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5				
6				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL		9,553,460		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM				
14				
15				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF		9,553,460		
PERIOD PER BALANCE SHEET				

	ENDOWMENT FUND		PLANT FUND	
	5	6	7	8
1 FUND BALANCE AT BEGINNING				
2 OF PERIOD				
2 NET INCOME (LOSS)				
3 TOTAL				
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
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				

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET G-2
 I I TO 12/31/2010 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	1,690,869		1,690,869
2 00 SUBPROVIDER			
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	1,690,869		1,690,869
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	1,690,869		1,690,869
17 00 ANCILLARY SERVICES	3,154,367	33,037,988	36,192,355
18 00 OUTPATIENT SERVICES	55,566	4,645,107	4,700,673
19 00 HOME HEALTH AGENCY			
20 00 AMBULANCE SERVICES		958,252	958,252
23 00 HOSPICE			
24 00		3,942,813	3,942,813
25 00 TOTAL PATIENT REVENUES	4,900,802	42,584,160	47,484,962

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES	21,070,761
ADD (SPECIFY)	
27 00 ADD (SPECIFY)	
28 00	
29 00	
30 00	
31 00	
32 00	
33 00 TOTAL ADDITIONS	
DEDUCT (SPECIFY)	
34 00 DEDUCT (SPECIFY)	
35 00	
36 00	
37 00	
38 00	
39 00 TOTAL DEDUCTIONS	
40 00 TOTAL OPERATING EXPENSES	21,070,761

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011
 I 15-1304 I FROM 1/ 1/2010 I WORKSHEET G-3
 I I TO 12/31/2010 I

DESCRIPTION

1	TOTAL PATIENT REVENUES	47,484,962
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	24,146,973
3	NET PATIENT REVENUES	23,337,989
4	LESS: TOTAL OPERATING EXPENSES	21,070,761
5	NET INCOME FROM SERVICE TO PATIENTS	2,267,228
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER OPERATING	925,056
24.01	NON-OPERATING REVENUE	395,153
25	TOTAL OTHER INCOME	1,320,209
26	TOTAL	3,587,437
	OTHER EXPENSES	
27	BAD DEBT EXPENSE	3,555,903
28		
29		
30	TOTAL OTHER EXPENSES	3,555,903
31	NET INCOME (OR LOSS) FOR THE PERIOD	31,534