

**ST. VINCENT RANDOLPH HOSPITAL
WINCHESTER, INDIANA**

**PROVIDER NOS. 15-1301, 15-Z301
AND AIM NO. 100270270A**

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

JUNE 30, 2010

ST. VINCENT RANDOLPH HOSPITAL

**PROVIDER NOS. 15-1301, 15-Z301
AND AIM NO. 100270270A**

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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Board of Directors
St. Vincent Randolph Hospital
Winchester, Indiana

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

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

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

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

Bradley Associates, Inc.

November 24, 2010

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)).
FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE
THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS
(42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	15-1301	I	FROM 7/ 1/2009	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 6/30/2010	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
						--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 11/24/2010 TIME 14:52

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
ST. VINCENT RANDOLPH HOSPITAL 15-1301
FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2009 AND ENDING 6/30/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
DATE: 11/24/2010 TIME 14:52

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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	356,989	111,752		0
3	SWING BED - SNF	0	29,551	0		0
100	TOTAL	0	386,540	111,752		0

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 473 GREENVILLE AVE. P.O. BOX:
 1.01 CITY: WINCHESTER STATE: IN ZIP CODE: 47934- COUNTY: RANDOLPH

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N)		
					V	XVIII	XIX
02.00	HOSPITAL	15-1301	2.01	1/ 1/2000	4	5	6
04.00	SWING BED - SNF	15-2301		9/ 1/1999	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 7/ 1/2009 TO: 6/30/2010
 18 TYPE OF CONTROL 1 2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
 20 SUBPROVIDER

OTHER INFORMATION

- 21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.
- 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.
- 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
- 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 Y
- 21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2
- 21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2
- 21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105 OR MIPPA §147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO. N
- 21.07 DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS). IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA SECTION 3121? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. (SEE INSTRUCTIONS) N N
- 21.08 WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEDING 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 AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)

25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)

26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0

26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 10/26/1998

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

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

	1	2	3	4
28.01				
28.02	0	0.0000	0.0000	

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

0.00 0

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

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

29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? N

30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) Y

30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70 N

30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS) N

30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000). N

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

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

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

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

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

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

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

MISCELLANEOUS COST REPORT INFORMATION

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

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

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

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

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

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

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

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

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

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

40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS). Y
 40.01 NAME: ST. VINCENT HEALTH FI/CONTRACTOR NAME NGS FI/CONTRACTOR # 15H046
 40.02 STREET: 10330 N. MERIDIAN ST. STE. 420 P.O. BOX:
 40.03 CITY: INDIANAPOLIS STATE: IN ZIP CODE: 46290-

41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2. N 00/00/0000
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?
 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?
 46 IF YOU ARE PARTICIPATING IN THE NHCNQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

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

	PART A	PART B	OUTPATIENT	OUTPATIENT	OUTPATIENT	DATE	Y OR N	LIMIT	Y OR N	FEES
			ASC	RADIOLOGY	DIAGNOSTIC					
	1	2	3	4	5	0	1	2	3	4
47.00 HOSPITAL	N	N	N	N	N					
52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS)										N
52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV										N
53 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.										0
53.01 MDH PERIOD: BEGINNING: / / ENDING: / /										
54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 0 PAID LOSSES: 0 AND/OR SELF INSURANCE: 0										
54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.										N
55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.										N
56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.										
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.							N	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). / /

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
I 15-1301 I FROM 7/ 1/2009 I WORKSHEET S-3
I I TO 6/30/2010 I PART I

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	I/P DAYS /		O/P VISITS /		TRIPS TOTAL TITLE XIX 5
				TITLE V 3	TITLE XVIII 4	NOT LTCH N/A 4.01		
1 ADULTS & PEDIATRICS	25	9,125	72,216.00		1,494			523
2 HMO								
2 01 HMO - (IRF PPS SUBPROVIDER)								
3 ADULTS & PED-SB SNF					304			
4 ADULTS & PED-SB NF								
5 TOTAL ADULTS AND PEDS	25	9,125	72,216.00		1,798			523
6 INTENSIVE CARE UNIT								
7 CORONARY CARE UNIT								
8 BURN INTENSIVE CARE UNIT								
9 SURGICAL INTENSIVE CARE UNIT								
11 NURSERY								272
12 TOTAL	25	9,125	72,216.00		1,798			795
13 RPCH VISITS								
14 SUBPROVIDER								
15 SKILLED NURSING FACILITY								
16 NURSING FACILITY								
16 01 ICF/MR								
17 OTHER LONG TERM CARE								
18 HOME HEALTH AGENCY								
20 AMBULATORY SURGICAL CENTER (
21 HOSPICE								
23 CORF								
24 RURAL HEALTH CLINIC								
25 TOTAL	25							
26 OBSERVATION BED DAYS								
27 AMBULANCE TRIPS								
28 EMPLOYEE DISCOUNT DAYS								
28 01 EMP DISCOUNT DAYS -IRF								
29 LABOR & DELIVERY DAYS								

COMPONENT	I/P DAYS /		O/P VISITS /	TRIPS		INTERNS & RES. FTES --	
	TITLE XIX OBSERVATION BEDS ADMITTED	NOT ADMITTED		TOTAL	LESS I&R REPL NON-PHYS ANES	TOTAL	
1 ADULTS & PEDIATRICS	5.01	5.02	6	6.01	6.02	7	8
2 HMO			3,009				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			304				
4 ADULTS & PED-SB NF			131				
5 TOTAL ADULTS AND PEDS			3,444				
6 INTENSIVE CARE UNIT							
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY			440				
12 TOTAL			3,884				
13 RPCH VISITS							
14 SUBPROVIDER							
15 SKILLED NURSING FACILITY							
16 NURSING FACILITY							
16 01 ICF/MR							
17 OTHER LONG TERM CARE							
18 HOME HEALTH AGENCY							
20 AMBULATORY SURGICAL CENTER (
21 HOSPICE							
23 CORF							
24 RURAL HEALTH CLINIC							
25 TOTAL							
26 OBSERVATION BED DAYS			848	183	665		
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS			68				
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	I & R FTES NET	FULL TIME EQUIV		DISCHARGES			
		EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS	9	10	11		416	229	1,028
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							
7 CORONARY CARE UNIT							

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

I PROVIDER NO:
I 15-1301
I

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

I PREPARED 11/24/2010
I WORKSHEET S-3
I PART I

COMPONENT	I & R FTES NET	--- FULL TIME EQUIV ---		TITLE V	DISCHARGES		TOTAL ALL PATIENTS
		EMPLOYEES ON PAYROLL	NONPAID WORKERS		TITLE XVIII	TITLE XIX	
8 BURN INTENSIVE CARE UNIT	9	10	11	12	13	14	15
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL		197.18			416	229	1,028
13 RPCH VISITS							
14 SUBPROVIDER							
15 SKILLED NURSING FACILITY							
16 NURSING FACILITY							
16 01 ICF/MR							
17 OTHER LONG TERM CARE							
18 HOME HEALTH AGENCY							
20 AMBULATORY SURGICAL CENTER (
21 HOSPICE							
23 CORF							
24 RURAL HEALTH CLINIC							
25 TOTAL		197.18					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I
I 15-1301 I
I I

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

I PREPARED 11/24/2010 I
I WORKSHEET A I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
1	0100 OLD CAP REL COSTS-BLDG & FIXT					
2	0200 OLD CAP REL COSTS-MVBLE EQUIP					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		1,650,860	1,650,860		1,650,860
4	0400 NEW CAP REL COSTS-MVBLE EQUIP					
5	0500 EMPLOYEE BENEFITS	216,437	2,988,543	3,204,980		3,204,980
6	0600 ADMINISTRATIVE & GENERAL	2,114,916	2,098,919	4,213,835	29,230	4,243,065
7	0700 MAINTENANCE & REPAIRS					
8	0800 OPERATION OF PLANT	206,721	912,908	1,119,629		1,119,629
9	0900 LAUNDRY & LINEN SERVICE		63,156	63,156		63,156
10	1000 HOUSEKEEPING	265,425	60,391	325,816		325,816
11	1100 DIETARY	276,886	126,017	402,903	-287,234	115,669
12	1200 CAFETERIA				287,234	287,234
13	1300 MAINTENANCE OF PERSONNEL					
14	1400 NURSING ADMINISTRATION	306,722	49,442	356,164		356,164
15	1500 CENTRAL SERVICES & SUPPLY					
16	1600 PHARMACY					
17	1700 MEDICAL RECORDS & LIBRARY	305,764	58,915	364,679		364,679
18	1800 SOCIAL SERVICE					
20	2000 NONPHYSICIAN ANESTHETISTS					
21	2100 NURSING SCHOOL					
22	2200 I&R SERVICES-SALARY & FRINGES APPRVD					
23	2300 I&R SERVICES-OTHER PRGM COSTS APPRVD					
24	2400 PARAMED ED PRGM					
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	2,458,246	154,890	2,613,136	-362,922	2,250,214
26	2600 INTENSIVE CARE UNIT					
27	2700 CORONARY CARE UNIT					
28	2800 BURN INTENSIVE CARE UNIT					
29	2900 SURGICAL INTENSIVE CARE UNIT					
31	3100 SUBPROVIDER					
33	3300 NURSERY				362,922	362,922
34	3400 SKILLED NURSING FACILITY					
35	3500 NURSING FACILITY					
35.01	3510 ICF/MR					
36	3600 OTHER LONG TERM CARE					
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	451,157	884,812	1,335,969	-349,039	986,930
38	3800 RECOVERY ROOM					
39	3900 DELIVERY ROOM & LABOR ROOM					
40	4000 ANESTHESIOLOGY	729,553	79,254	808,807	-800	808,007
41	4100 RADIOLOGY-DIAGNOSTIC	772,472	682,344	1,454,816		1,454,816
42	4200 RADIOLOGY-THERAPEUTIC					
43	4300 RADIOISOTOPE					
44	4400 LABORATORY	636,312	1,012,236	1,648,548		1,648,548
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	434,893	70,320	505,213	-124,640	380,573
50	5000 PHYSICAL THERAPY	196,518	140,016	336,534		336,534
51	5100 OCCUPATIONAL THERAPY	45,744	86,950	132,694		132,694
52	5200 SPEECH PATHOLOGY	1,635	20,051	21,686		21,686
53	5300 ELECTROCARDIOLOGY	26,781	11,451	38,232	100,201	138,433
54	5400 ELECTROENCEPHALOGRAPHY					
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	74,291	329,450	403,741	24,439	428,180
55.30	5530 IMPL. DEV. CHARGED TO PATIENT				349,039	349,039
56	5600 DRUGS CHARGED TO PATIENTS	256,577	485,682	742,259		742,259
57	5700 RENAL DIALYSIS					
58	5800 ASC (NON-DISTINCT PART)					
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC					
61	6100 EMERGENCY	818,420	1,636,485	2,454,905	-27,750	2,427,155
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950 OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310 RURAL HEALTH CLINIC					
	OTHER REIMBURS COST CNTRS					
64	6400 HOME PROGRAM DIALYSIS					
65	6500 AMBULANCE SERVICES					
66	6600 DURABLE MEDICAL EQUIP-RENTED					
67	6700 DURABLE MEDICAL EQUIP-SOLD					
69	6900 CORF					
70	7000 I&R SERVICES-NOT APPRVD PRGM					
71	7100 HOME HEALTH AGENCY					
	SPEC PURPOSE COST CENTERS					
82	8200 LUNG ACQUISITION					
83	8300 KIDNEY ACQUISITION					
84	8400 LIVER ACQUISITION					
85	8500 HEART ACQUISITION					
85.01	8510 PANCREAS ACQUISITION					
86	8600 OTHER ORGAN ACQUISITION					
88	8800 INTEREST EXPENSE					

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:
I 15-1301
I

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

I PREPARED 11/24/2010
I WORKSHEET A
I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	SPEC PURPOSE COST CENTERS					
89	8900 UTILIZATION REVIEW-SNF					
90	9000 OTHER CAPITAL RELATED COSTS					
92	9200 AMBULATORY SURGICAL CENTER (D.P.)					
93	9300 HOSPICE					
95	SUBTOTALS	10,595,470	13,603,092	24,198,562	680	24,199,242
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
97	9700 RESEARCH					
98	9800 PHYSICIANS' PRIVATE OFFICES					
99	9900 NONPAID WORKERS					
100	7950 OTHER NONREIMBURSABLE COST CENTERS	58,546	40,326	98,872		98,872
100.01	7951 FOUNDATION	60,433	81,998	142,431		142,431
100.02	7952 PUBLIC RELATIONS		5,812	5,812	-680	5,132
100.03	7953 WELLNESS		293	293		293
100.04	7954 MARKETING					
101	TOTAL	10,714,449	13,731,521	24,445,970	-0-	24,445,970

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:	I PERIOD:	I PREPARED
I 15-1301	I FROM 7/ 1/2009	I 11/24/2010
I	I TO 6/30/2010	I WORKSHEET A

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
1	0100 OLD CAP REL COSTS-BLDG & FIXT		
2	0200 OLD CAP REL COSTS-MVBLE EQUIP		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-126,760	1,524,100
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		
5	0500 EMPLOYEE BENEFITS	116,566	3,321,546
6	0600 ADMINISTRATIVE & GENERAL	449,614	4,692,679
7	0700 MAINTENANCE & REPAIRS		
8	0800 OPERATION OF PLANT	-5,592	1,114,037
9	0900 LAUNDRY & LINEN SERVICE		63,156
10	1000 HOUSEKEEPING		325,816
11	1100 DIETARY		115,669
12	1200 CAFETERIA	-88,167	199,067
13	1300 MAINTENANCE OF PERSONNEL		
14	1400 NURSING ADMINISTRATION		356,164
15	1500 CENTRAL SERVICES & SUPPLY		
16	1600 PHARMACY		
17	1700 MEDICAL RECORDS & LIBRARY		364,679
18	1800 SOCIAL SERVICE		
20	2000 NONPHYSICIAN ANESTHETISTS		
21	2100 NURSING SCHOOL		
22	2200 I&R SERVICES-SALARY & FRINGES APPRVD		
23	2300 I&R SERVICES-OTHER PRGM COSTS APPRVD		
24	2400 PARAMED ED PRGM		
25	2500 INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-480,170	1,770,044
26	2600 INTENSIVE CARE UNIT		
27	2700 CORONARY CARE UNIT		
28	2800 BURN INTENSIVE CARE UNIT		
29	2900 SURGICAL INTENSIVE CARE UNIT		
31	3100 SUBPROVIDER		
33	3300 NURSERY		362,922
34	3400 SKILLED NURSING FACILITY		
35	3500 NURSING FACILITY		
35.01	3510 ICF/MR		
36	3600 OTHER LONG TERM CARE		
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		986,930
38	3800 RECOVERY ROOM		
39	3900 DELIVERY ROOM & LABOR ROOM		
40	4000 ANESTHESIOLOGY	-773,536	34,471
41	4100 RADIOLOGY-DIAGNOSTIC	-92,430	1,362,386
42	4200 RADIOLOGY-THERAPEUTIC		
43	4300 RADIOISOTOPE		
44	4400 LABORATORY		1,648,548
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		380,573
50	5000 PHYSICAL THERAPY		336,534
51	5100 OCCUPATIONAL THERAPY	-17,076	115,618
52	5200 SPEECH PATHOLOGY	-3,900	17,786
53	5300 ELECTROCARDIOLOGY		138,433
54	5400 ELECTROENCEPHALOGRAPHY		
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		428,180
55.30	5530 IMPL. DEV. CHARGED TO PATIENT		349,039
56	5600 DRUGS CHARGED TO PATIENTS		742,259
57	5700 RENAL DIALYSIS		
58	5800 ASC (NON-DISTINCT PART)		
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC		
61	6100 EMERGENCY	-346,213	2,080,942
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950 OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310 RURAL HEALTH CLINIC		
	OTHER REIMBURS COST CNTRS		
64	6400 HOME PROGRAM DIALYSIS		
65	6500 AMBULANCE SERVICES		
66	6600 DURABLE MEDICAL EQUIP-RENTED		
67	6700 DURABLE MEDICAL EQUIP-SOLD		
69	6900 CORF		
70	7000 I&R SERVICES-NOT APPRVD PRGM		
71	7100 HOME HEALTH AGENCY		
	SPEC PURPOSE COST CENTERS		
82	8200 LUNG ACQUISITION		
83	8300 KIDNEY ACQUISITION		
84	8400 LIVER ACQUISITION		
85	8500 HEART ACQUISITION		
85.01	8510 PANCREAS ACQUISITION		
86	8600 OTHER ORGAN ACQUISITION		
88	8800 INTEREST EXPENSE		-0-

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:	I PERIOD:	I PREPARED
I 15-1301	I FROM 7/ 1/2009	I 11/24/2010
I	I TO 6/30/2010	I WORKSHEET A

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	SPEC PURPOSE COST CENTERS		
89	8900 UTILIZATION REVIEW-SNF		-0-
90	9000 OTHER CAPITAL RELATED COSTS		-0-
92	9200 AMBULATORY SURGICAL CENTER (D.P.)		
93	9300 HOSPICE		
95	SUBTOTALS	-1,367,664	22,831,578
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
97	9700 RESEARCH		
98	9800 PHYSICIANS' PRIVATE OFFICES		
99	9900 NONPAID WORKERS		
100	7950 OTHER NONREIMBURSABLE COST CENTERS		98,872
100.01	7951 FOUNDATION		142,431
100.02	7952 PUBLIC RELATIONS		5,132
100.03	7953 WELLNESS		293
100.04	7954 MARKETING	377,070	377,070
101	TOTAL	-990,594	23,455,376

COST CENTERS USED IN COST REPORT

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
1	OLD CAP REL COSTS-BLDG & FIXT	0100	
2	OLD CAP REL COSTS-MVBLE EQUIP	0200	
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
13	MAINTENANCE OF PERSONNEL	1300	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
20	NONPHYSICIAN ANESTHETISTS	2000	
21	NURSING SCHOOL	2100	
22	I&R SERVICES-SALARY & FRINGES APPRVD	2200	
23	I&R SERVICES-OTHER PRGM COSTS APPRVD	2300	
24	PARAMED ED PRGM	2400	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
27	CORONARY CARE UNIT	2700	
28	BURN INTENSIVE CARE UNIT	2800	
29	SURGICAL INTENSIVE CARE UNIT	2900	
31	SUBPROVIDER	3100	
33	NURSERY	3300	
34	SKILLED NURSING FACILITY	3400	
35	NURSING FACILITY	3500	
35.01	ICF/MR	3510	
36	OTHER LONG TERM CARE	3600	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
38	RECOVERY ROOM	3800	
39	DELIVERY ROOM & LABOR ROOM	3900	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
42	RADIOLOGY-THERAPEUTIC	4200	
43	RADIOISOTOPE	4300	
44	LABORATORY	4400	
45	PBP CLINICAL LAB SERVICES-PRGM ONLY	4500	
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	4600	
47	BLOOD STORING, PROCESSING & TRANS.	4700	
48	INTRAVENOUS THERAPY	4800	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
54	ELECTROENCEPHALOGRAPHY	5400	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
55.30	IMPL. DEV. CHARGED TO PATIENT	5530	IMPL. DEV. CHARGED TO PATIENT
56	DRUGS CHARGED TO PATIENTS	5600	
57	RENAL DIALYSIS	5700	
58	ASC (NON-DISTINCT PART)	5800	
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
64	HOME PROGRAM DIALYSIS	6400	
65	AMBULANCE SERVICES	6500	
66	DURABLE MEDICAL EQUIP-RENTED	6600	
67	DURABLE MEDICAL EQUIP-SOLD	6700	
69	CORF	6900	
70	I&R SERVICES-NOT APPRVD PRGM	7000	
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
82	LUNG ACQUISITION	8200	
83	KIDNEY ACQUISITION	8300	
84	LIVER ACQUISITION	8400	
85	HEART ACQUISITION	8500	
85.01	PANCREAS ACQUISITION	8510	
86	OTHER ORGAN ACQUISITION	8600	
88	INTEREST EXPENSE	8800	
89	UTILIZATION REVIEW-SNF	8900	

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
I 15-1301 I FROM 7/ 1/2009 I NOT A CMS WORKSHEET
I I TO 6/30/2010 I

COST CENTERS USED IN COST REPORT

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	SPEC PURPOSE COST CE		
90	OTHER CAPITAL RELATED COSTS	9000	
92	AMBULATORY SURGICAL CENTER (D.P.)	9200	
93	HOSPICE	9300	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
97	RESEARCH	9700	
98	PHYSICIANS' PRIVATE OFFICES	9800	
99	NONPAID WORKERS	9900	
100	OTHER NONREIMBURSABLE COST CENTERS	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	FOUNDATION	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	PUBLIC RELATIONS	7952	OTHER NONREIMBURSABLE COST CENTERS
100.03	WELLNESS	7953	OTHER NONREIMBURSABLE COST CENTERS
100.04	MARKETING	7954	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO: 151301	PERIOD: FROM 7/ 1/2009 TO 6/30/2010	PREPARED 11/24/2010 WORKSHEET A-6
------------------------	---	--------------------------------------

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1) COST CENTER		LINE NO	SALARY	OTHER
	1	2	3	4	5
1 CAFETERIA	A	CAFETERIA	12	197,395	89,839
2 OXYGEN	B	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		24,439
3 EKG	C	ELECTROCARDIOLOGY	53	86,254	13,947
4 NURSERY	D	NURSERY	33	341,410	21,512
5 ADVERTISING	E	ADMINISTRATIVE & GENERAL	6		680
6 DIRECTOR OF ER	I	ADMINISTRATIVE & GENERAL	6	27,750	
7		ADMINISTRATIVE & GENERAL	6	800	
8 IMPLANTABLE DEVICES	L	IMPL. DEV. CHARGED TO PATIENT	55.30		349,039
36 TOTAL RECLASSIFICATIONS				653,609	499,456

(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: 151301	PERIOD: FROM 7/ 1/2009 TO 6/30/2010	PREPARED 11/24/2010 WORKSHEET A-6
------------------------	---	--------------------------------------

EXPLANATION OF RECLASSIFICATION	DECREASE				A-7 REF 10
	CODE (1)	COST CENTER 6	LINE NO 7	SALARY 8	
1 CAFETERIA	A	DIETARY	11	197,395	89,839
2 OXYGEN	B	RESPIRATORY THERAPY	49		24,439
3 EKG	C	RESPIRATORY THERAPY	49	86,254	13,947
4 NURSERY	D	ADULTS & PEDIATRICS	25	341,410	21,512
5 ADVERTISING	E	PUBLIC RELATIONS	100.02		680
6 DIRECTOR OF ER	I	EMERGENCY	61	27,750	
7		ANESTHESIOLOGY	40	800	
8 IMPLANTABLE DEVICES	L	OPERATING ROOM	37		349,039
36 TOTAL RECLASSIFICATIONS				653,609	499,456

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED 11/24/2010
151301	FROM 7/ 1/2009	WORKSHEET A-6
	TO 6/30/2010	NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : CAFETERIA

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	CAFETERIA	287,234
TOTAL RECLASSIFICATIONS FOR CODE A		287,234

DECREASE		
COST CENTER	LINE	AMOUNT
DIETARY	11	287,234
		287,234

RECLASS CODE: B
EXPLANATION : OXYGEN

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	24,439
TOTAL RECLASSIFICATIONS FOR CODE B		24,439

DECREASE		
COST CENTER	LINE	AMOUNT
RESPIRATORY THERAPY	49	24,439
		24,439

RECLASS CODE: C
EXPLANATION : EKG

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	ELECTROCARDIOLOGY	100,201
TOTAL RECLASSIFICATIONS FOR CODE C		100,201

DECREASE		
COST CENTER	LINE	AMOUNT
RESPIRATORY THERAPY	49	100,201
		100,201

RECLASS CODE: D
EXPLANATION : NURSERY

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	NURSERY	362,922
TOTAL RECLASSIFICATIONS FOR CODE D		362,922

DECREASE		
COST CENTER	LINE	AMOUNT
ADULTS & PEDIATRICS	25	362,922
		362,922

RECLASS CODE: E
EXPLANATION : ADVERTISING

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	680
TOTAL RECLASSIFICATIONS FOR CODE E		680

DECREASE		
COST CENTER	LINE	AMOUNT
PUBLIC RELATIONS	100.02	680
		680

RECLASS CODE: I
EXPLANATION : DIRECTOR OF ER

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	27,750
2.00	ADMINISTRATIVE & GENERAL	800
TOTAL RECLASSIFICATIONS FOR CODE I		28,550

DECREASE		
COST CENTER	LINE	AMOUNT
EMERGENCY	61	27,750
ANESTHESIOLOGY	40	800
		28,550

RECLASS CODE: L
EXPLANATION : IMPLANTABLE DEVICES

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	IMPL. DEV. CHARGED TO PATIENT	349,039
TOTAL RECLASSIFICATIONS FOR CODE L		349,039

DECREASE		
COST CENTER	LINE	AMOUNT
OPERATING ROOM	37	349,039
		349,039

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING	ACQUISITIONS		TOTAL	DISPOSALS	ENDING	FULLY
		BALANCES	PURCHASES	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	ACQUISITIONS		TOTAL	DISPOSALS	ENDING	FULLY
		BALANCES	PURCHASES	DONATION		AND		BALANCE
		1	2	3	4	5	6	7
1	LAND	696,652					696,652	
2	LAND IMPROVEMENTS	49,953				24,853	25,100	
3	BUILDINGS & FIXTURE	18,107,406				156,597	17,950,809	
4	BUILDING IMPROVEMEN	63,998				63,998		
5	FIXED EQUIPMENT	450,800					450,800	
6	MOVABLE EQUIPMENT	7,303,632				1,958,260	5,345,372	
7	SUBTOTAL	26,672,441				2,203,708	24,468,733	
8	RECONCILING ITEMS							
9	TOTAL	26,672,441				2,203,708	24,468,733	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL
		GROSS ASSETS 1	CAPITIALIZED LEASES 2	GROSS ASSETS FOR RATIO 3	RATIO 4	INSURANCE 5	TAXES 6	
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	24,468,733		24,468,733	1.000000			
4	NEW CAP REL COSTS-MV							
5	TOTAL	24,468,733		24,468,733	1.000000			

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL					OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13		
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	1,866,617		-342,517				1,524,100
4	NEW CAP REL COSTS-MV							
5	TOTAL	1,866,617		-342,517				1,524,100

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL					OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13		
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	1,650,860						1,650,860
4	NEW CAP REL COSTS-MV							
5	TOTAL	1,650,860						1,650,860

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

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST. A-7 REF.
			COST CENTER	LINE NO	
	1	2	3	4	5
1			OLD CAP REL COSTS-BLDG &	1	
2			OLD CAP REL COSTS-MVBLE E	2	
3			NEW CAP REL COSTS-BLDG &	3	
4			NEW CAP REL COSTS-MVBLE E	4	
5					
6					
7					
8					
9					
10					
11					
12	A-8-2	-1,692,349			
13					
14	A-8-1	923,896			
15					
16	B	-88,167	CAFETERIA	12	
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			UTILIZATION REVIEW-SNF	89	
29			OLD CAP REL COSTS-BLDG &	1	
30			OLD CAP REL COSTS-MVBLE E	2	
31			NEW CAP REL COSTS-BLDG &	3	
32			NEW CAP REL COSTS-MVBLE E	4	
33			NONPHYSICIAN ANESTHETISTS	20	
34					
35	A-8-4	-17,076	OCCUPATIONAL THERAPY	51	
36	A-8-4	-3,900	SPEECH PATHOLOGY	52	
37	A	-2,267	ADMINISTRATIVE & GENERAL	6	
38	B	-55,636	ADMINISTRATIVE & GENERAL	6	
39					
40					
40.01					
40.02					
40.03	A	-1,004	ADMINISTRATIVE & GENERAL	6	
40.04	A	40,384	ADMINISTRATIVE & GENERAL	6	
40.05	A	-2,462	NEW CAP REL COSTS-BLDG &	3	9
41					
42	A	-5,592	OPERATION OF PLANT	8	
43	A	-104,668	NEW CAP REL COSTS-BLDG &	3	9
44	A	-2,507	NEW CAP REL COSTS-BLDG &	3	9
45	A	20,754	ADMINISTRATIVE & GENERAL	6	
46					
47					
48					
49					
49.01					
50		-990,594			

(1) Description - all chapter references in this column pertain to CMS Pub. 15-I.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to worksheet A-7

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	3	NEW CAP REL COSTS-BLDG & HOME OFFICE	325,394		325,394	9
2	6	ADMINISTRATIVE & GENERAL HOME OFFICE	2,086,154	1,530,931	555,223	9
3	100 4	MARKETING HOME OFFICE	377,070		377,070	9
4	6	ADMINISTRATIVE & GENERAL ASCENSION - INTEREST		82,352	-82,352	11
4.02	3	NEW CAP REL COSTS-BLDG & ASCENSION - INTEREST		342,517	-342,517	11
4.04	6	ADMINISTRATIVE & GENERAL ASCENSION - MAINTENANCE	313,224	338,712	-25,488	9
4.05	10	HOUSEKEEPING ST. VINCENT HEALTH - CHAR	-41,978	-41,978		
4.06	8	OPERATION OF PLANT ST. VINCENT HEALTH - CHAR	-644	-644		
4.07	17	MEDICAL RECORDS & LIBRARY ST. VINCENT HEALTH - CHAR	34,500	34,500		
4.08	41	RADIOLOGY-DIAGNOSTIC ST. VINCENT HEALTH - CHAR	1,314	1,314		
4.09	56	DRUGS CHARGED TO PATIENTS ST. VINCENT HEALTH - CHAR	3,456	3,456		
4.10	6	ADMINISTRATIVE & GENERAL ST. VINCENT HEALTH - CHAR	598,888	598,888		
4.11	10	HOUSEKEEPING ST. VINCENT HEALTH - CHAR	-12,593	-12,593		
4.12	5	EMPLOYEE BENEFITS ST. VINCENT HEALTH - CHAR	195,325	195,325		
4.13	6	ADMINISTRATIVE & GENERAL ST. VINCENT HEALTH - CHAR	75,684	75,684		
4.14	8	OPERATION OF PLANT ST. VINCENT HEALTH - CHAR	-1,476	-1,476		
4.15	6	ADMINISTRATIVE & GENERAL ST. VINCENT HEALTH - CHAR	1,530,931	1,530,931		
4.16	10	HOUSEKEEPING ST. VINCENT HEALTH - CHAR	-6,823	-6,823		
4.17	17	MEDICAL RECORDS & LIBRARY ST. VINCENT HEALTH - CHAR	23,671	23,671		
4.18	6	ADMINISTRATIVE & GENERAL ST. VINCENT HEALTH - CHAR	219	219		
4.19	25	ADULTS & PEDIATRICS ST. VINCENT HEALTH - CHAR	7,417	7,417		
4.20	56	DRUGS CHARGED TO PATIENTS ST. VINCENT HEALTH - CHAR	-105,262	-105,262		
4.24	6	ADMINISTRATIVE & GENERAL ST. VINCENT HEALTH - CHAR	5,812	5,812		
4.27	8	OPERATION OF PLANT ST. VINCENT HEALTH - CHAR	-7	-7		
4.28	6	ADMINISTRATIVE & GENERAL ST. VINCENT HEALTH - CHAR	166,283	166,283		
4.30	5	EMPLOYEE BENEFITS SELF INSURANCE	1,221,229	1,104,663	116,566	
4.31	5	EMPLOYEE BENEFITS PENSION	464,123	464,123		
5		TOTALS	7,261,911	6,338,015	923,896	

* 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	
	2	3	4	5	6	
1	G	ST. VINCENT HEALTH	100.00	ST. VINCENT HEALTH	100.00	ADMINISTRATION
2	B	ASCENSION	100.00	ASCENSION	100.00	ADMINISTRATION
3	B	ST. VINCENT HOSPITAL	100.00	ST. VINCENT HOSPITAL	100.00	HOSPITAL
4			0.00		0.00	
5			0.00		0.00	

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I 15-1301
I

I PERIOD: I PREPARED 11/24/2010
I FROM 7/ 1/2009 I WORKSHEET A-8-2
I TO 6/30/2010 I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1 40	ANESTHESIA	796,065	773,536	22,529				
2 25	HOSPITALISTS	492,886	480,170	12,716				
3 41	RADIOLOGY	92,430	92,430					
4 61	ER	1,549,050	346,213	1,202,837				
5 44	LAB	32,392		32,392				
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	2,962,823	1,692,349	1,270,474				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET A-8-2
 I I TO 6/30/2010 I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF COL 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COL 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
10	11	12	13	14	15	16	17	18
1	40 ANESTHESIA							773,536
2	25 HOSPITALISTS							480,170
3	41 RADIOLOGY							92,430
4	61 ER							346,213
5	44 LAB							
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL							1,692,349

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

I PROVIDER NO: I 15-1301 I

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

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

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	17
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	255
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	95
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	4.85
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		777.00	1343.00	
10	AHSEA (SEE INSTRUCTIONS)	85.45	68.36	51.27	
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	34.18	34.18	25.64	
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	53,116
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	68,856
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	121,972
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	121,972

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	121,972

PART III - SALARY AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	3,247
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	3,247
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	461
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	3,708
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	

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

I PROVIDER NO: I 15-1301 I

I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/24/2010 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

30 ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)
 31 SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
 32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)
 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 3,708
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT
 57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 121,972
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 3,708

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

I PROVIDER NO: I 15-1301
I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010
I PREPARED 11/24/2010 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60	OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)	
61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	125,680
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	106,079
65	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	
PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES		
66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	106,079
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	106,079
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

OCCUPATIONAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	17
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	255
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	84
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	4.85
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED	684.00			
10	AHSEA (SEE INSTRUCTIONS)	81.01	64.81		
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	32.41	32.41		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	55,411
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	55,411
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	55,411

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	55,411

PART III - SALARY AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	2,722
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	2,722
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	407
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	3,129
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	

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

I PROVIDER NO: I 15-1301 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/24/2010 I WORKSHEET A-8-4 I PARTS I - VII

OCCUPATIONAL THERAPY

- 30 ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)
- 31 SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
- 32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)
- 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 3,129
- 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
- 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

- 57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 55,411
- 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 3,129

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

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET A-8-4
 I I TO 6/30/2010 I PARTS I - VII

OCCUPATIONAL THERAPY

59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60	OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)	
61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	58,540
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	75,616
65	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	17,076
PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES		
66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	75,616
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	75,616
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	17,076
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	17,076

SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	15
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	225
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	23
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	4.85
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED	246.00			
10	AHSEA (SEE INSTRUCTIONS)	62.29			
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	31.15	31.15		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	15,323
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	15,323
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	15,323

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	15,323

PART III - SALARY AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	716
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	716
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	112
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	828
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	

SPEECH PATHOLOGY

59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60	OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)	
61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	16,151
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	20,051
65	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	3,900
PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES		
66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	20,051
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	20,051
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	3,900
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	3,900

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I NOT A CMS WORKSHEET
 I I TO 6/30/2010 I

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

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	OLD CAP REL C OSTS-BLDG &	OLD CAP REL C OSTS-MVBLE E	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL
	0	1	2	3	4	5	5a.00
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &	1,524,100			1,524,100			
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS	3,321,546					3,321,546	
007 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	4,692,679			239,755		788,624	5,721,058
008 OPERATION OF PLANT	1,114,037			91,069		69,776	1,274,882
009 LAUNDRY & LINEN SERVICE	63,156			12,433			75,589
010 HOUSEKEEPING	325,816			11,656		89,590	427,062
011 DIETARY	115,669			43,242		26,831	185,742
012 CAFETERIA	199,067			10,179		66,628	275,874
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION	356,164			2,797		44,865	403,826
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY	364,679			28,809		103,206	496,694
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	1,770,044			204,652		714,508	2,689,204
026 INTENSIVE CARE UNIT							
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
031 SUBPROVIDER							
033 NURSERY	362,922			2,428		115,238	480,588
034 SKILLED NURSING FACILITY							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS OPERATING ROOM	986,930			150,065		152,282	1,289,277
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO				45,632			45,632
040 ANESTHESIOLOGY	34,471						34,471
041 RADIOLOGY-DIAGNOSTIC	1,362,386			120,888		246,817	1,730,091
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY	1,648,548			33,859		228,699	1,911,106
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	380,573			24,652		117,678	522,903
050 PHYSICAL THERAPY	336,534			52,217		66,332	455,083
051 OCCUPATIONAL THERAPY	115,618			6,158		17,302	139,078
052 SPEECH PATHOLOGY	17,786			6,158		552	24,496
053 ELECTROCARDIOLOGY	138,433					29,114	167,547
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED	428,180			32,694		25,076	485,950
055 30 IMPL. DEV. CHARGED TO PAT	349,039						349,039
056 DRUGS CHARGED TO PATIENTS	742,259			14,220		84,742	841,221
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS CLINIC							
061 EMERGENCY	2,080,942			82,541		266,880	2,430,363
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC							
064 OTHER REIMBURS COST CNTRS HOME PROGRAM DIALYSIS							
065 AMBULANCE SERVICES							
066 DURABLE MEDICAL EQUIP-REN							
067 DURABLE MEDICAL EQUIP-SOL							
069 CORF							
070 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
083 SPEC PURPOSE COST CENTERS KIDNEY ACQUISITION							
084 LIVER ACQUISITION							
085 HEART ACQUISITION							
085 01 PANCREAS ACQUISITION							
086 OTHER ORGAN ACQUISITION							

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	0	1	2	3	4	5	EMPLOYEE BENE FITS	SUBTOTAL
092 SPEC PURPOSE COST CENTERS									5a.00
093 AMBULATORY SURGICAL CENTE									
095 HOSPICE									
095 SUBTOTALS	22,831,578				1,216,104		3,254,740		22,456,776
096 NONREIMBURS COST CENTERS									
096 GIFT, FLOWER, COFFEE SHOP					2,487				2,487
097 RESEARCH									
098 PHYSICIANS' PRIVATE OFFIC									
099 NONPAID WORKERS									
100 OTHER NONREIMBURSABLE COS	98,872				302,945		46,408		448,225
100 01 FOUNDATION	142,431				1,282		20,398		164,111
100 02 PUBLIC RELATIONS	5,132				1,282				6,414
100 03 WELLNESS	293								293
100 04 MARKETING	377,070								377,070
101 CROSS FOOT ADJUSTMENT									
102 NEGATIVE COST CENTER									
103 TOTAL	23,455,376				1,524,100		3,321,546		23,455,376

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART I

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA
	6	7	8	9	10	11	12
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	5,721,058						
008 OPERATION OF PLANT	411,274		1,686,156				
009 LAUNDRY & LINEN SERVICE	24,385		17,568	117,542			
010 HOUSEKEEPING	137,769		16,470		581,301		
011 DIETARY	59,920		61,103		21,499	328,264	
012 CAFETERIA	88,996		14,384		5,061		384,315
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION	130,273		3,953		1,391		6,410
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY	160,232		40,708		14,323		22,222
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	867,539		289,183	57,318	101,750	328,264	104,509
026 INTENSIVE CARE UNIT							
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
031 SUBPROVIDER							
033 NURSERY	155,037		3,431		1,207		16,856
034 SKILLED NURSING FACILITY							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS OPERATING ROOM	415,918		212,049	16,883	74,610		21,797
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO	14,721		64,479		22,687		
040 ANESTHESIOLOGY	11,120						
041 RADIOLOGY-DIAGNOSTIC	558,124		170,820	9,113	60,103		39,128
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY	616,519		47,845		16,834		52,115
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	168,687		34,834		12,256		19,725
050 PHYSICAL THERAPY	146,809		73,785		25,961		10,598
051 OCCUPATIONAL THERAPY	44,866		8,702		3,062		2,352
052 SPEECH PATHOLOGY	7,902		8,702		3,062		58
053 ELECTROCARDIOLOGY	54,050						4,880
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED	156,766		46,198		16,255		8,055
055 30 IMPL. DEV. CHARGED TO PAT	112,599						
056 DRUGS CHARGED TO PATIENTS	271,376		20,093		7,070		8,829
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS CLINIC							
061 EMERGENCY	784,030		116,634	34,228	41,038		47,659
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC							
064 OTHER REIMBURS COST CNTRS							
065 HOME PROGRAM DIALYSIS							
066 AMBULANCE SERVICES							
067 DURABLE MEDICAL EQUIP-REN							
069 DURABLE MEDICAL EQUIP-SOL CORF							
070 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
083 SPEC PURPOSE COST CENTERS							
084 KIDNEY ACQUISITION							
085 LIVER ACQUISITION							
085 HEART ACQUISITION							
085 01 PANCREAS ACQUISITION							
086 OTHER ORGAN ACQUISITION							

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART I

COST CENTER DESCRIPTION	ADMINISTRATIV	MAINTENANCE &	OPERATION OF	LAUNDRY & LIN	HOUSEKEEPING	DIETARY	CAFETERIA
	E & GENERAL	REPAIRS	PLANT	EN SERVICE			
	6	7	8	9	10	11	12
092 SPEC PURPOSE COST CENTERS							
093 AMBULATORY SURGICAL CENTE							
095 HOSPICE							
095 SUBTOTALS	5,398,912		1,250,941	117,542	428,169	328,264	365,193
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP	802		3,514		1,236		
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS	144,596		428,077		150,622		16,111
100 01 FOUNDATION	52,942		1,812		637		3,011
100 02 PUBLIC RELATIONS	2,069		1,812		637		
100 03 WELLNESS	95						
100 04 MARKETING	121,642						
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	5,721,058		1,686,156	117,542	581,301	328,264	384,315

COST ALLOCATION - GENERAL SERVICE COSTS
 I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART I

COST CENTER DESCRIPTION	13	14	15	16	17	18	20
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE							
011 HOUSEKEEPING							
012 DIETARY							
013 CAFETERIA							
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION		545,853					
016 CENTRAL SERVICES & SUPPLY							
017 PHARMACY							
018 MEDICAL RECORDS & LIBRARY					734,179		
019 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS		303,980			61,229		
027 INTENSIVE CARE UNIT							
028 CORONARY CARE UNIT							
029 BURN INTENSIVE CARE UNIT							
031 SURGICAL INTENSIVE CARE U							
033 SUBPROVIDER							
035 NURSERY					6,577		
034 SKILLED NURSING FACILITY							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM		63,398			54,763		
039 RECOVERY ROOM							
040 DELIVERY ROOM & LABOR ROO					2,385		
041 ANESTHESIOLOGY					5,551		
042 RADIOLOGY-DIAGNOSTIC					195,657		
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
045 LABORATORY					164,501		
046 PBP CLINICAL LAB SERVICES							
047 WHOLE BLOOD & PACKED RED							
048 BLOOD STORING, PROCESSING							
049 INTRAVENOUS THERAPY							
050 RESPIRATORY THERAPY					16,864		
051 PHYSICAL THERAPY					22,708		
052 OCCUPATIONAL THERAPY					3,969		
053 SPEECH PATHOLOGY					113		
054 ELECTROCARDIOLOGY					9,696		
055 ELECTROENCEPHALOGRAPHY							
055 30 MEDICAL SUPPLIES CHARGED					29,359		
056 IMPL. DEV. CHARGED TO PAT					10,996		
057 DRUGS CHARGED TO PATIENTS					57,175		
058 RENAL DIALYSIS							
060 ASC (NON-DISTINCT PART)							
061 OUTPAT SERVICE COST CNTRS							
062 CLINIC							
062 EMERGENCY		131,615			92,636		
063 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC							
064 OTHER REIMBURS COST CNTRS							
065 HOME PROGRAM DIALYSIS							
066 AMBULANCE SERVICES							
067 DURABLE MEDICAL EQUIP-REN							
069 DURABLE MEDICAL EQUIP-SOL							
070 CORF							
071 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
083 SPEC PURPOSE COST CENTERS							
084 KIDNEY ACQUISITION							
084 LIVER ACQUISITION							
085 HEART ACQUISITION							
085 01 PANCREAS ACQUISITION							
086 OTHER ORGAN ACQUISITION							

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART I

COST CENTER DESCRIPTION	MAINTENANCE O F PERSONNEL	NURSING ADMIN ISTRATION	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	NONPHYSICIAN ANESTHETISTS
	13	14	15	16	17	18	20
092 SPEC PURPOSE COST CENTERS							
093 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS		498,993			734,179		
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP							
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS		46,860					
100 01 FOUNDATION							
100 02 PUBLIC RELATIONS							
100 03 WELLNESS							
100 04 MARKETING							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL		545,853			734,179		

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART I

COST CENTER DESCRIPTION	NURSING SCHOOL I&R SERVICES- I&R SERVICES- PARAMED ED PR SUBTOTAL				I&R COST POST STEP-DOWN ADJ	TOTAL	
	L	SALARY & FRI	OTHER PRGM C	GM			
	21	22	23	24	25	26	27
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE							
011 HOUSEKEEPING							
012 DIETARY							
013 CAFETERIA							
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION							
016 CENTRAL SERVICES & SUPPLY							
017 PHARMACY							
018 MEDICAL RECORDS & LIBRARY							
020 SOCIAL SERVICE							
021 NONPHYSICIAN ANESTHETISTS							
022 NURSING SCHOOL							
023 I&R SERVICES-SALARY & FRI							
024 I&R SERVICES-OTHER PRGM C							
025 PARAMED ED PRGM							
026 INPAT ROUTINE SRVC CNTRS							
027 ADULTS & PEDIATRICS					4,802,976		4,802,976
028 INTENSIVE CARE UNIT							
029 CORONARY CARE UNIT							
031 BURN INTENSIVE CARE UNIT							
033 SURGICAL INTENSIVE CARE U							
034 SUBPROVIDER							
035 NURSERY					663,696		663,696
036 SKILLED NURSING FACILITY							
035 01 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM					2,148,695		2,148,695
039 RECOVERY ROOM							
040 DELIVERY ROOM & LABOR ROO					149,904		149,904
041 ANESTHESIOLOGY					51,142		51,142
042 RADIOLOGY-DIAGNOSTIC					2,763,036		2,763,036
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
045 LABORATORY					2,808,920		2,808,920
046 PBP CLINICAL LAB SERVICES							
047 WHOLE BLOOD & PACKED RED							
048 BLOOD STORING, PROCESSING							
049 INTRAVENOUS THERAPY							
050 RESPIRATORY THERAPY					775,269		775,269
051 PHYSICAL THERAPY					734,944		734,944
052 OCCUPATIONAL THERAPY					202,029		202,029
053 SPEECH PATHOLOGY					44,333		44,333
054 ELECTROCARDIOLOGY					236,173		236,173
055 ELECTROENCEPHALOGRAPHY							
055 30 MEDICAL SUPPLIES CHARGED					742,583		742,583
056 30 IMPL. DEV. CHARGED TO PAT					472,634		472,634
057 DRUGS CHARGED TO PATIENTS					1,205,764		1,205,764
058 RENAL DIALYSIS							
060 ASC (NON-DISTINCT PART)							
061 OUTPAT SERVICE COST CNTRS							
062 CLINIC							
063 EMERGENCY					3,678,203		3,678,203
063 50 OBSERVATION BEDS (NON-DIS							
063 50 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC							
064 OTHER REIMBURS COST CNTRS							
065 HOME PROGRAM DIALYSIS							
066 AMBULANCE SERVICES							
067 DURABLE MEDICAL EQUIP-REN							
069 DURABLE MEDICAL EQUIP-SOL							
070 CORF							
071 I&R SERVICES-NOT APPRVD P							
072 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
083 SPEC PURPOSE COST CENTERS							
084 KIDNEY ACQUISITION							
085 LIVER ACQUISITION							
085 01 HEART ACQUISITION							
086 01 PANCREAS ACQUISITION							
086 OTHER ORGAN ACQUISITION							

COST ALLOCATION - GENERAL SERVICE COSTS.

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART I

COST CENTER DESCRIPTION	NURSING SCHOO L	I&R SERVICES- SALARY & FRI	I&R SERVICES- OTHER PRGM C	PARAMED ED PR	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	21	22	23	24	25	26	27
092 SPEC PURPOSE COST CENTERS							
093 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS					21,480,301		21,480,301
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP					8,039		8,039
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS					1,234,491		1,234,491
100 01 FOUNDATION					222,513		222,513
100 02 PUBLIC RELATIONS					10,932		10,932
100 03 WELLNESS					388		388
100 04 MARKETING					498,712		498,712
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL					23,455,376		23,455,376

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS 0	OLD CAP REL C OSTS-BLDG & 1	OLD CAP REL C OSTS-MVBLE E 2	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-MVBLE E 4	SUBTOTAL 4a	EMPLOYEE BENEFITS 5
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL				239,755		239,755	
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT				91,069		91,069	
010 LAUNDRY & LINEN SERVICE				12,433		12,433	
011 HOUSEKEEPING				11,656		11,656	
012 DIETARY				43,242		43,242	
013 CAFETERIA				10,179		10,179	
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION				2,797		2,797	
016 CENTRAL SERVICES & SUPPLY							
017 PHARMACY							
018 MEDICAL RECORDS & LIBRARY				28,809		28,809	
020 SOCIAL SERVICE							
021 NONPHYSICIAN ANESTHETISTS							
022 NURSING SCHOOL							
023 I&R SERVICES-SALARY & FRI							
024 I&R SERVICES-OTHER PRGM C							
025 PARAMED ED PRGM							
026 INPAT ROUTINE SRVC CNTRS							
027 ADULTS & PEDIATRICS				204,652		204,652	
028 INTENSIVE CARE UNIT							
029 CORONARY CARE UNIT							
031 BURN INTENSIVE CARE UNIT							
033 SURGICAL INTENSIVE CARE U							
034 SUBPROVIDER							
035 NURSERY				2,428		2,428	
036 SKILLED NURSING FACILITY							
035 01 NURSING FACILITY							
036 01 ICF/MR							
037 OTHER LONG TERM CARE							
038 ANCILLARY SRVC COST CNTRS							
039 OPERATING ROOM				150,065		150,065	
040 RECOVERY ROOM							
041 DELIVERY ROOM & LABOR ROO				45,632		45,632	
042 ANESTHESIOLOGY							
043 RADIOLOGY-DIAGNOSTIC				120,888		120,888	
044 RADIOLOGY-THERAPEUTIC							
045 RADIOISOTOPE							
046 LABORATORY				33,859		33,859	
047 PBP CLINICAL LAB SERVICES							
048 WHOLE BLOOD & PACKED RED							
049 BLOOD STORING, PROCESSING							
050 INTRAVENOUS THERAPY							
051 RESPIRATORY THERAPY				24,652		24,652	
052 PHYSICAL THERAPY				52,217		52,217	
053 OCCUPATIONAL THERAPY				6,158		6,158	
054 SPEECH PATHOLOGY				6,158		6,158	
055 ELECTROCARDIOLOGY							
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED				32,694		32,694	
056 30 IMPL. DEV. CHARGED TO PAT							
057 DRUGS CHARGED TO PATIENTS				14,220		14,220	
058 RENAL DIALYSIS							
060 ASC (NON-DISTINCT PART)							
061 OUTPAT SERVICE COST CNTRS							
062 CLINIC							
063 EMERGENCY				82,541		82,541	
064 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC							
064 OTHER REIMBURS COST CNTRS							
065 HOME PROGRAM DIALYSIS							
066 AMBULANCE SERVICES							
067 DURABLE MEDICAL EQUIP-REN							
069 DURABLE MEDICAL EQUIP-SOL							
070 CORF							
071 I&R SERVICES-NOT APPRVD P							
082 HOME HEALTH AGENCY							
083 LUNG ACQUISITION							
084 SPEC PURPOSE COST CENTERS							
085 KIDNEY ACQUISITION							
084 LIVER ACQUISITION							
085 HEART ACQUISITION							
085 01 PANCREAS ACQUISITION							
086 OTHER ORGAN ACQUISITION							

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS 0	OLD CAP REL C OSTS-BLDG & 1	OLD CAP REL C OSTS-MVBLE E 2	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-MVBLE E 4	SUBTOTAL 4a	EMPLOYEE BENE FITS 5
092 SPEC PURPOSE COST CENTERS							
093 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS				1,216,104		1,216,104	
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP				2,487		2,487	
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS				302,945		302,945	
100 01 FOUNDATION				1,282		1,282	
100 02 PUBLIC RELATIONS				1,282		1,282	
100 03 WELLNESS							
100 04 MARKETING							
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL				1,524,100		1,524,100	

COST CENTER DESCRIPTION	ADMINISTRATIVE MAINTENANCE & OPERATION OF		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	E & GENERAL	REPAIRS					PLANT
	6	7	8	9	10	11	12
GENERAL SERVICE COST CNTR							
OLD CAP REL COSTS-BLDG & OLD CAP REL COSTS-MVBLE E							
NEW CAP REL COSTS-BLDG & NEW CAP REL COSTS-MVBLE E							
EMPLOYEE BENEFITS							
ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	239,755						
OPERATION OF PLANT	17,235		108,304				
LAUNDRY & LINEN SERVICE	1,022		1,128	14,583			
HOUSEKEEPING	5,773		1,058		18,487		
DIETARY	2,511		3,925		684	50,362	
CAFETERIA	3,730		924		161		14,994
MAINTENANCE OF PERSONNEL							
NURSING ADMINISTRATION	5,459		254		44		250
CENTRAL SERVICES & SUPPLY PHARMACY							
MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	6,715		2,615		456		867
NONPHYSICIAN ANESTHETISTS NURSING SCHOOL							
I&R SERVICES-SALARY & FRI I&R SERVICES-OTHER PRGM C							
PARAMED ED PRGM							
INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	36,359		18,575	7,110	3,236	50,362	4,079
INTENSIVE CARE UNIT CORONARY CARE UNIT							
BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE U							
SUBPROVIDER							
NURSERY	6,497		220		38		658
SKILLED NURSING FACILITY NURSING FACILITY							
ICF/MR							
OTHER LONG TERM CARE							
ANCILLARY SRVC COST CNTRS							
OPERATING ROOM	17,430		13,620	2,095	2,373		850
RECOVERY ROOM							
DELIVERY ROOM & LABOR ROO	617		4,142		722		
ANESTHESIOLOGY	466						
RADIOLOGY-DIAGNOSTIC	23,389		10,972	1,131	1,911		1,527
RADIOLOGY-THERAPEUTIC							
RADIOISOTOPE							
LABORATORY	25,836		3,073		535		2,033
PBP CLINICAL LAB SERVICES							
WHOLE BLOOD & PACKED RED BLOOD STORING, PROCESSING							
INTRAVENOUS THERAPY							
RESPIRATORY THERAPY	7,069		2,237		390		770
PHYSICAL THERAPY	6,152		4,739		826		413
OCCUPATIONAL THERAPY	1,880		559		97		92
SPEECH PATHOLOGY	331		559		97		2
ELECTROCARDIOLOGY	2,265						190
ELECTROENCEPHALOGRAPHY							
MEDICAL SUPPLIES CHARGED	6,570		2,967		517		314
IMPL. DEV. CHARGED TO PAT	4,719						
DRUGS CHARGED TO PATIENTS	11,372		1,291		225		344
RENAL DIALYSIS							
ASC (NON-DISTINCT PART)							
OUTPAT SERVICE COST CNTRS							
CLINIC							
EMERGENCY	32,856		7,492	4,247	1,305		1,859
OBSERVATION BEDS (NON-DIS							
OTHER OUTPATIENT SERVICE							
RURAL HEALTH CLINIC							
OTHER REIMBURS COST CNTRS							
HOME PROGRAM DIALYSIS							
AMBULANCE SERVICES							
DURABLE MEDICAL EQUIP-REN							
DURABLE MEDICAL EQUIP-SOL							
CORF							
I&R SERVICES-NOT APPRVD P							
HOME HEALTH AGENCY							
LUNG ACQUISITION							
SPEC PURPOSE COST CENTERS							
KIDNEY ACQUISITION							
LIVER ACQUISITION							
HEART ACQUISITION							
PANCREAS ACQUISITION							
OTHER ORGAN ACQUISITION							

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART III

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA
	6	7	8	9	10	11	12
SPEC PURPOSE COST CENTERS							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	226,253		80,350	14,583	13,617	50,362	14,248
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP	34		226		39		
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS	6,060		27,496		4,791		629
100 01 FOUNDATION	2,219		116		20		117
100 02 PUBLIC RELATIONS	87		116		20		
100 03 WELLNESS	4						
100 04 MARKETING	5,098						
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	239,755		108,304	14,583	18,487	50,362	14,994

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART III

COST CENTER DESCRIPTION	MAINTENANCE F PERSONNEL 13	NURSING ADMIN ISTRATION 14	CENTRAL SERVI CES & SUPPLY 15	PHARMACY 16	MEDICAL RECOR DS & LIBRARY 17	SOCIAL SERVIC E 18	NONPHYSICIAN ANESTHETISTS 20
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE							
011 HOUSEKEEPING							
012 DIETARY							
013 CAFETERIA							
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION		8,804					
016 CENTRAL SERVICES & SUPPLY							
017 PHARMACY							
018 MEDICAL RECORDS & LIBRARY					39,462		
019 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS		4,902			3,289		
027 INTENSIVE CARE UNIT							
028 CORONARY CARE UNIT							
029 BURN INTENSIVE CARE UNIT							
030 SURGICAL INTENSIVE CARE U							
031 SUBPROVIDER							
032 NURSERY					353		
033 SKILLED NURSING FACILITY							
034 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM		1,023			2,942		
039 RECOVERY ROOM							
040 DELIVERY ROOM & LABOR ROO					128		
041 ANESTHESIOLOGY					298		
042 RADIOLOGY-DIAGNOSTIC					10,531		
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
045 LABORATORY					8,838		
046 PBP CLINICAL LAB SERVICES							
047 WHOLE BLOOD & PACKED RED							
048 BLOOD STORING, PROCESSING							
049 INTRAVENOUS THERAPY							
050 RESPIRATORY THERAPY					906		
051 PHYSICAL THERAPY					1,220		
052 OCCUPATIONAL THERAPY					213		
053 SPEECH PATHOLOGY					6		
054 ELECTROCARDIOLOGY					521		
055 ELECTROENCEPHALOGRAPHY							
056 MEDICAL SUPPLIES CHARGED					1,577		
057 30 IMPL. DEV. CHARGED TO PAT					591		
058 DRUGS CHARGED TO PATIENTS					3,072		
059 RENAL DIALYSIS							
060 ASC (NON-DISTINCT PART)							
061 OUTPAT SERVICE COST CNTRS							
062 CLINIC							
063 EMERGENCY		2,123			4,977		
064 OBSERVATION BEDS (NON-DIS							
065 OTHER OUTPATIENT SERVICE							
066 50 RURAL HEALTH CLINIC							
067 OTHER REIMBURS COST CNTRS							
068 HOME PROGRAM DIALYSIS							
069 AMBULANCE SERVICES							
070 DURABLE MEDICAL EQUIP-REN							
071 DURABLE MEDICAL EQUIP-SOL							
072 CORF							
073 I&R SERVICES-NOT APPRVD P							
074 HOME HEALTH AGENCY							
075 LUNG ACQUISITION							
076 SPEC PURPOSE COST CENTERS							
077 KIDNEY ACQUISITION							
078 LIVER ACQUISITION							
079 HEART ACQUISITION							
080 01 PANCREAS ACQUISITION							
081 OTHER ORGAN ACQUISITION							

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART III

COST CENTER DESCRIPTION	MAINTENANCE O F PERSONNEL	NURSING ADMIN ISTRATION	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	NONPHYSICIAN ANESTHETISTS
	13	14	15	16	17	18	20
092 SPEC PURPOSE COST CENTERS							
093 AMBULATORY SURGICAL CENTE							
095 HOSPICE							
095 SUBTOTALS		8,048			39,462		
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP							
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS		756					
100 01 FOUNDATION							
100 02 PUBLIC RELATIONS							
100 03 WELLNESS							
100 04 MARKETING							
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		8,804			39,462		

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B
 I I TO 6/30/2010 I PART III

COST CENTER DESCRIPTION	NURSING SCHOOL	I&R SERVICES-SALARY & FRI	I&R SERVICES-OTHER PRGM C	PARAMED ED PRGM	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	21	22	23	24	25	26	27
GENERAL SERVICE COST CNTR							
001 OLD CAP REL COSTS-BLDG &							
002 OLD CAP REL COSTS-MVBLE E							
003 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING							
011 DIETARY							
012 CAFETERIA							
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION							
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY							
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS					332,564		332,564
026 INTENSIVE CARE UNIT							
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
031 SUBPROVIDER							
033 NURSERY					10,194		10,194
034 SKILLED NURSING FACILITY							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM					190,398		190,398
039 RECOVERY ROOM							
040 DELIVERY ROOM & LABOR ROO					51,241		51,241
041 ANESTHESIOLOGY					764		764
042 RADIOLOGY-DIAGNOSTIC					170,349		170,349
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
045 LABORATORY					74,174		74,174
046 PBP CLINICAL LAB SERVICES							
047 WHOLE BLOOD & PACKED RED							
048 BLOOD STORING, PROCESSING							
049 INTRAVENOUS THERAPY							
050 RESPIRATORY THERAPY					36,024		36,024
051 PHYSICAL THERAPY					65,567		65,567
052 OCCUPATIONAL THERAPY					8,999		8,999
053 SPEECH PATHOLOGY					7,153		7,153
054 ELECTROCARDIOLOGY					2,976		2,976
055 ELECTROENCEPHALOGRAPHY							
055 30 MEDICAL SUPPLIES CHARGED					44,639		44,639
056 IMPL. DEV. CHARGED TO PAT					5,310		5,310
057 DRUGS CHARGED TO PATIENTS					30,524		30,524
058 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
062 EMERGENCY					137,400		137,400
063 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC							
064 OTHER REIMBURS COST CNTRS							
065 HOME PROGRAM DIALYSIS							
066 AMBULANCE SERVICES							
067 DURABLE MEDICAL EQUIP-REN							
069 DURABLE MEDICAL EQUIP-SOL							
070 CORF							
071 I&R SERVICES-NOT APPRVD P							
082 HOME HEALTH AGENCY							
083 LUNG ACQUISITION							
084 SPEC PURPOSE COST CENTERS							
085 KIDNEY ACQUISITION							
085 01 LIVER ACQUISITION							
085 HEART ACQUISITION							
085 01 PANCREAS ACQUISITION							
086 OTHER ORGAN ACQUISITION							

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
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 I I TO 6/30/2010 I PART III

COST CENTER DESCRIPTION	NURSING SCHOOL	I&R SERVICES- SALARY & FRI	I&R SERVICES- OTHER PRGM C	PARAMED ED PR GM	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	21	22	23	24	25	26	27
092 SPEC PURPOSE COST CENTERS							
093 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS					1,168,276		1,168,276
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP					2,786		2,786
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS					342,677		342,677
100 01 FOUNDATION					3,754		3,754
100 02 PUBLIC RELATIONS					1,505		1,505
100 03 WELLNESS					4		4
100 04 MARKETING					5,098		5,098
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL					1,524,100		1,524,100

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B-1
 I I TO 6/30/2010 I

COST CENTER DESCRIPTION	OLD CAP REL C	OLD CAP REL C	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	S RECONCIL-) IATION
	OSTS-BLDG &	OSTS-MVBLE E	OSTS-BLDG &	OSTS-MVBLE E	FITS	
	(SQUARE FEET	(DOLLAR)VALUE	(SQUARE) FEET	(DOLLAR)VALUE	(GROSS)ALARIES	
	1	2	3	4	5	6a.00
001 GENERAL SERVICE COST						
002 OLD CAP REL COSTS-BLD						
003 OLD CAP REL COSTS-MVB						
004 NEW CAP REL COSTS-BLD			78,457			
005 NEW CAP REL COSTS-MVB						
006 EMPLOYEE BENEFITS					9,840,579	
007 ADMINISTRATIVE & GENE			12,342		2,336,426	-5,721,058
008 MAINTENANCE & REPAIRS						
009 OPERATION OF PLANT			4,688		206,721	
010 LAUNDRY & LINEN SERVI			640			
011 HOUSEKEEPING			600		265,425	
012 DIETARY			2,226		79,491	
013 CAFETERIA			524		197,395	
014 MAINTENANCE OF PERSON						
015 NURSING ADMINISTRATIO			144		132,920	
016 CENTRAL SERVICES & SU						
017 PHARMACY						
018 MEDICAL RECORDS & LIB			1,483		305,764	
019 SOCIAL SERVICE						
020 NONPHYSICIAN ANESTHET						
021 NURSING SCHOOL						
022 I&R SERVICES-SALARY &						
023 I&R SERVICES-OTHER PR						
024 PARAMED ED PRGM						
025 INPAT ROUTINE SRVC CN			10,535		2,116,836	
026 ADULTS & PEDIATRICS						
027 INTENSIVE CARE UNIT						
028 CORONARY CARE UNIT						
029 BURN INTENSIVE CARE U						
030 SURGICAL INTENSIVE CA						
031 SUBPROVIDER						
032 NURSERY			125		341,410	
033 SKILLED NURSING FACIL						
034 NURSING FACILITY						
035 01 ICF/MR						
036 OTHER LONG TERM CARE						
037 ANCILLARY SRVC COST C						
038 OPERATING ROOM			7,725		451,157	
039 RECOVERY ROOM						
040 DELIVERY ROOM & LABOR			2,349			
041 ANESTHESIOLOGY						
042 RADIOLOGY-DIAGNOSTIC			6,223		731,231	
043 RADIOLOGY-THERAPEUTIC						
044 RADIOISOTOPE						
045 LABORATORY			1,743		677,553	
046 PBP CLINICAL LAB SERV						
047 WHOLE BLOOD & PACKED						
048 BLOOD STORING, PROCES						
049 INTRAVENOUS THERAPY						
050 RESPIRATORY THERAPY			1,269		348,638	
051 PHYSICAL THERAPY			2,688		196,518	
052 OCCUPATIONAL THERAPY			317		51,261	
053 SPEECH PATHOLOGY			317		1,635	
054 ELECTROCARDIOLOGY					86,254	
055 ELECTROENCEPHALOGRAPH						
056 MEDICAL SUPPLIES CHAR			1,683		74,291	
057 30 IMPL. DEV. CHARGED TO						
058 DRUGS CHARGED TO PATI			732		251,060	
059 RENAL DIALYSIS						
060 ASC (NON-DISTINCT PAR						
061 OUTPAT SERVICE COST C						
062 CLINIC						
063 EMERGENCY			4,249		790,670	
064 OBSERVATION BEDS (NON						
065 OTHER OUTPATIENT SERV						
066 50 RURAL HEALTH CLINIC						
067 OTHER REIMBURS COST C						
068 HOME PROGRAM DIALYSIS						
069 AMBULANCE SERVICES						
070 DURABLE MEDICAL EQUIP						
071 DURABLE MEDICAL EQUIP						
072 CORF						
073 I&R SERVICES-NOT APPR						
074 HOME HEALTH AGENCY						
075 LUNG ACQUISITION						
076 SPEC PURPOSE COST CEN						
077 KIDNEY ACQUISITION						

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	OLD CAP REL C	OLD CAP REL C	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	S RECONCIL-) IATION
	OSTS-BLDG &	OSTS-MVBLE E	OSTS-BLDG &	OSTS-MVBLE E	FITS	
	(SQUARE FEET	(DOLLAR)VALUE	(SQUARE) FEET	(DOLLAR)VALUE	(GROSS)ALARIES	
	1	2	3	4	5	6a.00
SPEC PURPOSE COST CEN						
LIVER ACQUISITION						
HEART ACQUISITION						
1 PANCREAS ACQUISITION						
OTHER ORGAN ACQUISITI						
AMBULATORY SURGICAL C						
HOSPICE						
SUBTOTALS			62,602		9,642,656	-5,721,058
NONREIMBURS COST CENT						
GIFT, FLOWER, COFFEE			128			
RESEARCH						
PHYSICIANS' PRIVATE O						
NONPAID WORKERS						
OTHER NONREIMBURSABLE			15,595		137,490	
1 FOUNDATION			66		60,433	
2 PUBLIC RELATIONS			66			
3 WELLNESS						
4 MARKETING						
CROSS FOOT ADJUSTMENT						
NEGATIVE COST CENTER						
COST TO BE ALLOCATED			1,524,100		3,321,546	
(WRKSHT B, PART I)						
UNIT COST MULTIPLIER			19.425928		.337536	
(WRKSHT B, PT I)						
COST TO BE ALLOCATED						
(WRKSHT B, PART II)						
UNIT COST MULTIPLIER						
(WRKSHT B, PT II)						
COST TO BE ALLOCATED						
(WRKSHT B, PART III)						
UNIT COST MULTIPLIER						
(WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B-1
 I I TO 6/30/2010 I

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA
	(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF) LAUNDRY	(SQUARE FEET)	(MEALS) SERVED	(HOURS)
	6	7	8	9	10	11	12
001 GENERAL SERVICE COST							
002 OLD CAP REL COSTS-BLD							
003 OLD CAP REL COSTS-MVB							
004 NEW CAP REL COSTS-BLD							
005 NEW CAP REL COSTS-MVB							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENE	17,734,318						
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT	1,274,882		61,427				
010 LAUNDRY & LINEN SERVI	75,589		640	104,703			
011 HOUSEKEEPING	427,062		600		60,187		
012 DIETARY	185,742		2,226		2,226	100	
013 CAFETERIA	275,874		524		524		253,263
014 MAINTENANCE OF PERSON							
015 NURSING ADMINISTRATIO	403,826		144		144		4,224
016 CENTRAL SERVICES & SU							
017 PHARMACY							
018 MEDICAL RECORDS & LIB	496,694		1,483		1,483		14,644
019 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHET							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY &							
023 I&R SERVICES-OTHER PR							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CN	2,689,204		10,535	51,057	10,535	100	68,873
026 ADULTS & PEDIATRICS							
027 INTENSIVE CARE UNIT							
028 CORONARY CARE UNIT							
029 BURN INTENSIVE CARE U							
030 SURGICAL INTENSIVE CA							
031 SUBPROVIDER							
032 NURSERY	480,588		125		125		11,108
033 SKILLED NURSING FACIL							
034 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST C							
038 OPERATING ROOM	1,289,277		7,725	15,039	7,725		14,364
039 RECOVERY ROOM							
040 DELIVERY ROOM & LABOR	45,632		2,349		2,349		
041 ANESTHESIOLOGY	34,471						
042 RADIOLOGY-DIAGNOSTIC	1,730,091		6,223	8,118	6,223		25,785
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
045 LABORATORY	1,911,106		1,743		1,743		34,344
046 PBP CLINICAL LAB SERV							
047 WHOLE BLOOD & PACKED							
048 BLOOD STORING, PROCES							
049 INTRAVENOUS THERAPY							
050 RESPIRATORY THERAPY	522,903		1,269		1,269		12,999
051 PHYSICAL THERAPY	455,083		2,688		2,688		6,984
052 OCCUPATIONAL THERAPY	139,078		317		317		1,550
053 SPEECH PATHOLOGY	24,496		317		317		38
054 ELECTROCARDIOLOGY	167,547						3,216
055 ELECTROENCEPHALOGRAPH							
056 MEDICAL SUPPLIES CHAR	485,950		1,683		1,683		5,308
057 30 IMPL. DEV. CHARGED TO	349,039						
058 DRUGS CHARGED TO PATI	841,221		732		732		5,818
059 RENAL DIALYSIS							
060 ASC (NON-DISTINCT PAR							
061 OUTPAT SERVICE COST C							
062 CLINIC							
063 EMERGENCY	2,430,363		4,249	30,489	4,249		31,407
064 OBSERVATION BEDS (NON							
065 OTHER OUTPATIENT SERV							
066 50 RURAL HEALTH CLINIC							
067 OTHER REIMBURS COST C							
068 HOME PROGRAM DIALYSIS							
069 AMBULANCE SERVICES							
070 DURABLE MEDICAL EQUIP							
071 DURABLE MEDICAL EQUIP							
072 CORF							
073 I&R SERVICES-NOT APPR							
074 HOME HEALTH AGENCY							
075 LUNG ACQUISITION							
076 SPEC PURPOSE COST CEN							
077 KIDNEY ACQUISITION							

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B-1
 I I TO 6/30/2010 I

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA
	(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF LAUNDRY)	(SQUARE FEET)	(MEALS SERVED)	(HOURS)
	6	7	8	9	10	11	12
084 SPEC PURPOSE COST CEN							
085 LIVER ACQUISITION							
085 01 HEART ACQUISITION							
086 01 PANCREAS ACQUISITION							
086 OTHER ORGAN ACQUISITION							
092 AMBULATORY SURGICAL C							
093 HOSPICE							
095 SUBTOTALS	16,735,718		45,572	104,703	44,332	100	240,662
NONREIMBURS COST CENT							
096 GIFT, FLOWER, COFFEE	2,487		128		128		
097 RESEARCH							
098 PHYSICIANS' PRIVATE O							
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE	448,225		15,595		15,595		10,617
100 01 FOUNDATION	164,111		66		66		1,984
100 02 PUBLIC RELATIONS	6,414		66		66		
100 03 WELLNESS	293						
100 04 MARKETING	377,070						
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED (WRKSHT B, PART I)	5,721,058		1,686,156	117,542	581,301	328,264	384,315
104 UNIT COST MULTIPLIER (WRKSHT B, PT I)	.322598		27.449753	1.122623	9.658248	3,282.640000	1.517454
105 COST TO BE ALLOCATED (WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER (WRKSHT B, PT II)							
107 COST TO BE ALLOCATED (WRKSHT B, PART III)	239,755		108,304	14,583	18,487	50,362	14,994
108 UNIT COST MULTIPLIER (WRKSHT B, PT III)	.013519		1.763133	.139280	.307159	503.620000	.059203

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B-1
 I I TO 6/30/2010 I

COST CENTER DESCRIPTION	MAINTENANCE O F PERSONNEL	NURSING ADMIN ISTRATION	CENTRAL SERVI CES & SUPPLY	PHARMACY R(COSTED)EQUIS.	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	NONPHYSICIAN ANESTHETISTS
	(NUMBER HOUSED	(DIRECT)SING HRS	NR(COSTED)EQUIS.	R(COSTED)EQUIS.	R(GROSS)HARGES	C(TIME)SPENT	(ASSIGNED) TIME
	13	14	15	16	17	18	20
001 GENERAL SERVICE COST							
002 OLD CAP REL COSTS-BLD							
003 OLD CAP REL COSTS-MVB							
004 NEW CAP REL COSTS-BLD							
005 NEW CAP REL COSTS-MVB							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENE							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVI							
011 HOUSEKEEPING							
012 DIETARY							
013 CAFETERIA							
014 MAINTENANCE OF PERSON							
015 NURSING ADMINISTRATIO		123,674		100			
016 CENTRAL SERVICES & SU							
017 PHARMACY					100		
018 MEDICAL RECORDS & LIB						59,315,024	
020 SOCIAL SERVICE							
021 NONPHYSICIAN ANESTHET							
022 NURSING SCHOOL							
023 I&R SERVICES-SALARY &							
024 I&R SERVICES-OTHER PR							
025 PARAMED ED PRGM							
026 INPAT ROUTINE SRVC CN							
027 ADULTS & PEDIATRICS		68,873				4,946,586	
028 INTENSIVE CARE UNIT							
029 CORONARY CARE UNIT							
031 BURN INTENSIVE CARE U							
033 SURGICAL INTENSIVE CA							
034 SUBPROVIDER							
035 NURSERY						531,384	
036 SKILLED NURSING FACIL							
037 NURSING FACILITY							
038 01 ICF/MR							
039 OTHER LONG TERM CARE							
040 ANCILLARY SRVC COST C							
041 OPERATING ROOM		14,364				4,424,189	
042 RECOVERY ROOM							
043 DELIVERY ROOM & LABOR						192,720	
044 ANESTHESIOLOGY						448,474	
045 RADIOLOGY-DIAGNOSTIC						15,808,620	
046 RADIOLOGY-THERAPEUTIC							
047 RADIOISOTOPE							
048 LABORATORY						13,289,791	
049 PBP CLINICAL LAB SERV							
050 WHOLE BLOOD & PACKED							
051 BLOOD STORING, PROCES							
052 INTRAVENOUS THERAPY						1,362,430	
053 RESPIRATORY THERAPY						1,834,546	
054 PHYSICAL THERAPY						320,663	
055 OCCUPATIONAL THERAPY						9,145	
056 SPEECH PATHOLOGY						783,320	
057 ELECTROCARDIOLOGY							
058 ELECTROENCEPHALOGRAPH							
059 MEDICAL SUPPLIES CHAR				100		2,371,840	
060 30 IMPL. DEV. CHARGED TO						888,370	
061 DRUGS CHARGED TO PATI					100	4,619,044	
062 RENAL DIALYSIS							
063 ASC (NON-DISTINCT PAR							
064 OUTPAT SERVICE COST C							
065 CLINIC							
066 EMERGENCY		29,820				7,483,902	
067 OBSERVATION BEDS (NON							
068 OTHER OUTPATIENT SERV							
069 50 RURAL HEALTH CLINIC							
070 OTHER REIMBURS COST C							
071 HOME PROGRAM DIALYSIS							
072 AMBULANCE SERVICES							
073 DURABLE MEDICAL EQUIP							
074 DURABLE MEDICAL EQUIP							
075 CORF							
076 I&R SERVICES-NOT APPR							
077 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
083 SPEC PURPOSE COST CEN							
084 KIDNEY ACQUISITION							

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B-1
 I I TO 6/30/2010 I

COST CENTER DESCRIPTION	MAINTENANCE O	NURSING ADMIN	CENTRAL SERVI	PHARMACY	MEDICAL RECOR	SOCIAL SERVIC	NONPHYSICIAN
	F PERSONNEL	ISTRATION	CES & SUPPLY		DS & LIBRARY	E	ANESTHETISTS
	(NUMBER HOUSED)	(DIRECT)SING HRS	NR(COSTED)EQUIS.	R(COSTED)EQUIS.	R(GROSS)HARGES	C(TIME)SPENT	(ASSIGNED) TIME
	13	14	15	16	17	18	20
084 SPEC PURPOSE COST CEN							
085 LIVER ACQUISITION							
085 01 HEART ACQUISITION							
085 01 PANCREAS ACQUISITION							
086 OTHER ORGAN ACQUISITI							
092 AMBULATORY SURGICAL C							
093 HOSPICE							
095 SUBTOTALS		113,057	100	100	59,315,024		
096 NONREIMBURS COST CENT							
096 GIFT, FLOWER, COFFEE							
097 RESEARCH							
098 PHYSICIANS' PRIVATE O							
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE		10,617					
100 01 FOUNDATION							
100 02 PUBLIC RELATIONS							
100 03 WELLNESS							
100 04 MARKETING							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED		545,853			734,179		
(WRKSHT B, PART I)							
104 UNIT COST MULTIPLIER		4.413644			.012378		
(WRKSHT B, PT I)							
105 COST TO BE ALLOCATED							
(WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER							
(WRKSHT B, PT II)							
107 COST TO BE ALLOCATED		8,804			39,462		
(WRKSHT B, PART III)							
108 UNIT COST MULTIPLIER		.071187			.000665		
(WRKSHT B, PT III)							

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET B-1
 I I TO 6/30/2010 I

COST CENTER DESCRIPTION	NURSING SCHOO	I&R SERVICES-	I&R SERVICES-	PARAMED ED PR
	L	SALARY & FRI	OTHER PRGM C	GM
	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)
	21	22	23	24
001	GENERAL SERVICE COST			
002	OLD CAP REL COSTS-BLD			
003	OLD CAP REL COSTS-MVB			
004	NEW CAP REL COSTS-BLD			
005	NEW CAP REL COSTS-MVB			
006	EMPLOYEE BENEFITS			
007	ADMINISTRATIVE & GENE			
008	MAINTENANCE & REPAIRS			
009	OPERATION OF PLANT			
010	LAUNDRY & LINEN SERVI			
011	HOUSEKEEPING			
012	DIETARY			
013	CAFETERIA			
014	MAINTENANCE OF PERSON			
015	NURSING ADMINISTRATIO			
016	CENTRAL SERVICES & SU			
017	PHARMACY			
018	MEDICAL RECORDS & LIB			
019	SOCIAL SERVICE			
020	NONPHYSICIAN ANESTHET			
021	NURSING SCHOOL			
022	I&R SERVICES-SALARY &			
023	I&R SERVICES-OTHER PR			
024	PARAMED ED PRGM			
025	INPAT ROUTINE SRVC CN			
026	ADULTS & PEDIATRICS			
027	INTENSIVE CARE UNIT			
028	CORONARY CARE UNIT			
029	BURN INTENSIVE CARE U			
030	SURGICAL INTENSIVE CA			
031	SUBPROVIDER			
032	NURSERY			
033	SKILLED NURSING FACIL			
034	NURSING FACILITY			
035	01 ICF/MR			
036	OTHER LONG TERM CARE			
037	ANCILLARY SRVC COST C			
038	OPERATING ROOM			
039	RECOVERY ROOM			
040	DELIVERY ROOM & LABOR			
041	ANESTHESIOLOGY			
042	RADIOLOGY-DIAGNOSTIC			
043	RADIOLOGY-THERAPEUTIC			
044	RADIOISOTOPE			
045	LABORATORY			
046	PBP CLINICAL LAB SERV			
047	WHOLE BLOOD & PACKED			
048	BLOOD STORING, PROCES			
049	INTRAVENOUS THERAPY			
050	RESPIRATORY THERAPY			
051	PHYSICAL THERAPY			
052	OCCUPATIONAL THERAPY			
053	SPEECH PATHOLOGY			
054	ELECTROCARDIOLOGY			
055	ELECTROENCEPHALOGRAPH			
056	MEDICAL SUPPLIES CHAR			
057	30 IMPL. DEV. CHARGED TO			
058	DRUGS CHARGED TO PATI			
059	RENAL DIALYSIS			
060	ASC (NON-DISTINCT PAR			
061	OUTPAT SERVICE COST C			
062	CLINIC			
063	EMERGENCY			
064	OBSERVATION BEDS (NON			
065	OTHER OUTPATIENT SERV			
066	50 RURAL HEALTH CLINIC			
067	OTHER REIMBURS COST C			
068	HOME PROGRAM DIALYSIS			
069	AMBULANCE SERVICES			
070	DURABLE MEDICAL EQUIP			
071	DURABLE MEDICAL EQUIP			
072	CORF			
073	I&R SERVICES-NOT APPR			
074	HOME HEALTH AGENCY			
075	LUNG ACQUISITION			
076	SPEC PURPOSE COST CEN			
077	KIDNEY ACQUISITION			

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO:
I 15-1301
I

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

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

COST CENTER DESCRIPTION	NURSING SCHOO I&R SERVICES- I&R SERVICES- PARAMED ED PR			
	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)
	21	22	23	24
084 SPEC PURPOSE COST CEN				
084 LIVER ACQUISITION				
085 HEART ACQUISITION				
085 01 PANCREAS ACQUISITION				
086 OTHER ORGAN ACQUISITI				
092 AMBULATORY SURGICAL C				
093 HOSPICE				
095 SUBTOTALS				
NONREIMBURS COST CEN				
096 GIFT, FLOWER, COFFEE				
097 RESEARCH				
098 PHYSICIANS' PRIVATE O				
099 NONPAID WORKERS				
100 OTHER NONREIMBURSABLE				
100 01 FOUNDATION				
100 02 PUBLIC RELATIONS				
100 03 WELLNESS				
100 04 MARKETING				
101 CROSS FOOT ADJUSTMENT				
102 NEGATIVE COST CENTER				
103 COST TO BE ALLOCATED				
(PER WRKSHT B, PART				
104 UNIT COST MULTIPLIER				
(WRKSHT B, PT I)				
105 COST TO BE ALLOCATED				
(PER WRKSHT B, PART				
106 UNIT COST MULTIPLIER				
(WRKSHT B, PT II)				
107 COST TO BE ALLOCATED				
(PER WRKSHT B, PART				
108 UNIT COST MULTIPLIER				
(WRKSHT B, PT III)				

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET C
 I I TO 6/30/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	4,802,976		4,802,976		
26	INTENSIVE CARE UNIT					
27	CORONARY CARE UNIT					
28	BURN INTENSIVE CARE UNIT					
29	SURGICAL INTENSIVE CARE U					
31	SUBPROVIDER					
33	NURSERY	663,696		663,696		
34	SKILLED NURSING FACILITY					
35	NURSING FACILITY					
35	01 ICF/MR					
36	OTHER LONG TERM CARE					
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	2,148,695		2,148,695		
38	RECOVERY ROOM					
39	DELIVERY ROOM & LABOR ROO	149,904		149,904		
40	ANESTHESIOLOGY	51,142		51,142		
41	RADIOLOGY-DIAGNOSTIC	2,763,036		2,763,036		
42	RADIOLOGY-THERAPEUTIC					
43	RADIOISOTOPE					
44	LABORATORY	2,808,920		2,808,920		
45	PBP CLINICAL LAB SERVICES					
46	WHOLE BLOOD & PACKED RED					
47	BLOOD STORING, PROCESSING					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	775,269		775,269		
50	PHYSICAL THERAPY	734,944		734,944		
51	OCCUPATIONAL THERAPY	202,029		202,029		
52	SPEECH PATHOLOGY	44,333		44,333		
53	ELECTROCARDIOLOGY	236,173		236,173		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	742,583		742,583		
55	30 IMPL. DEV. CHARGED TO PAT	472,634		472,634		
56	DRUGS CHARGED TO PATIENTS	1,205,764		1,205,764		
57	RENAL DIALYSIS					
58	ASC (NON-DISTINCT PART)					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	3,678,203		3,678,203		
62	OBSERVATION BEDS (NON-DIS	974,844		974,844		
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC					
	OTHER REIMBURS COST CNTRS					
64	HOME PROGRAM DIALYSIS					
65	AMBULANCE SERVICES					
66	DURABLE MEDICAL EQUIP-REN					
67	DURABLE MEDICAL EQUIP-SOL					
101	SUBTOTAL	22,455,145		22,455,145		
102	LESS OBSERVATION BEDS	974,844		974,844		
103	TOTAL	21,480,301		21,480,301		

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	4,946,586		4,946,586			
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
31	SUBPROVIDER						
33	NURSERY	531,384		531,384			
34	SKILLED NURSING FACILITY						
35	NURSING FACILITY						
35	01 ICF/MR						
36	OTHER LONG TERM CARE						
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	1,236,553	3,187,636	4,424,189	.485670	.485670	
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO	192,720		192,720	.777833	.777833	
40	ANESTHESIOLOGY	85,313	363,161	448,474	.114036	.114036	
41	RADIOLOGY-DIAGNOSTIC	1,162,926	14,645,694	15,808,620	.174780	.174780	
42	RADIOLOGY-THERAPEUTIC						
43	RADIOISOTOPE						
44	LABORATORY	1,753,714	11,536,076	13,289,790	.211359	.211359	
45	PBP CLINICAL LAB SERVICES						
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	833,737	528,693	1,362,430	.569034	.569034	
50	PHYSICAL THERAPY	263,696	1,570,850	1,834,546	.400614	.400614	
51	OCCUPATIONAL THERAPY	89,993	230,670	320,663	.630035	.630035	
52	SPEECH PATHOLOGY	2,974	6,171	9,145	4.847786	4.847786	
53	ELECTROCARDIOLOGY	68,795	714,525	783,320	.301503	.301503	
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	1,885,423	486,417	2,371,840	.313083	.313083	
55	30 IMPL. DEV. CHARGED TO PAT	627,377	260,993	888,370	.532024	.532024	
56	DRUGS CHARGED TO PATIENTS	2,273,339	2,345,705	4,619,044	.261042	.261042	
57	RENAL DIALYSIS						
58	ASC (NON-DISTINCT PART)						
60	OUTPAT SERVICE COST CNTRS CLINIC						
61	EMERGENCY	328,055	7,155,847	7,483,902	.491482	.491482	
62	OBSERVATION BEDS (NON-DIS		759,213	759,213	1.284019	1.284019	
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC						
64	OTHER REIMBURS COST CNTRS						
64	HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	16,282,585	43,791,651	60,074,236			
102	LESS OBSERVATION BEDS						
103	TOTAL	16,282,585	43,791,651	60,074,236			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO:
I 15-1301
I

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

I PREPARED 11/24/2010
I WORKSHEET C
I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	4,802,976		4,802,976		
26	INTENSIVE CARE UNIT					
27	CORONARY CARE UNIT					
28	BURN INTENSIVE CARE UNIT					
29	SURGICAL INTENSIVE CARE U					
31	SUBPROVIDER					
33	NURSERY	663,696		663,696		
34	SKILLED NURSING FACILITY					
35	NURSING FACILITY					
35	01 ICF/MR					
36	OTHER LONG TERM CARE					
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	2,148,695		2,148,695		
38	RECOVERY ROOM					
39	DELIVERY ROOM & LABOR ROO	149,904		149,904		
40	ANESTHESIOLOGY	51,142		51,142		
41	RADIOLOGY-DIAGNOSTIC	2,763,036		2,763,036		
42	RADIOLOGY-THERAPEUTIC					
43	RADIOISOTOPE					
44	LABORATORY	2,808,920		2,808,920		
45	PBP CLINICAL LAB SERVICES					
46	WHOLE BLOOD & PACKED RED					
47	BLOOD STORING, PROCESSING					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	775,269		775,269		
50	PHYSICAL THERAPY	734,944		734,944		
51	OCCUPATIONAL THERAPY	202,029		202,029		
52	SPEECH PATHOLOGY	44,333		44,333		
53	ELECTROCARDIOLOGY	236,173		236,173		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	742,583		742,583		
55	30 IMPL. DEV. CHARGED TO PAT	472,634		472,634		
56	DRUGS CHARGED TO PATIENTS	1,205,764		1,205,764		
57	RENAL DIALYSIS					
58	ASC (NON-DISTINCT PART)					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	3,678,203		3,678,203		
62	OBSERVATION BEDS (NON-DIS	974,844		974,844		
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC					
	OTHER REIMBURS COST CNTRS					
64	HOME PROGRAM DIALYSIS					
65	AMBULANCE SERVICES					
66	DURABLE MEDICAL EQUIP-REN					
67	DURABLE MEDICAL EQUIP-SOL					
101	SUBTOTAL	22,455,145		22,455,145		
102	LESS OBSERVATION BEDS	974,844		974,844		
103	TOTAL	21,480,301		21,480,301		

COMPUTATION OF RATIO OF COSTS TO CHARGES
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	4,946,586		4,946,586			
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
31	SUBPROVIDER						
33	NURSERY	531,384		531,384			
34	SKILLED NURSING FACILITY						
35	NURSING FACILITY						
35	01 ICF/MR						
36	OTHER LONG TERM CARE						
37	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,236,553	3,187,636	4,424,189	.485670	.485670	
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO	192,720		192,720	.777833	.777833	
40	ANESTHESIOLOGY	85,313	363,161	448,474	.114036	.114036	
41	RADIOLOGY-DIAGNOSTIC	1,162,926	14,645,694	15,808,620	.174780	.174780	
42	RADIOLOGY-THERAPEUTIC						
43	RADIOISOTOPE						
44	LABORATORY	1,753,714	11,536,076	13,289,790	.211359	.211359	
45	PBP CLINICAL LAB SERVICES						
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	833,737	528,693	1,362,430	.569034	.569034	
50	PHYSICAL THERAPY	263,696	1,570,850	1,834,546	.400614	.400614	
51	OCCUPATIONAL THERAPY	89,993	230,670	320,663	.630035	.630035	
52	SPEECH PATHOLOGY	2,974	6,171	9,145	4.847786	4.847786	
53	ELECTROCARDIOLOGY	68,795	714,525	783,320	.301503	.301503	
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	1,885,423	486,417	2,371,840	.313083	.313083	
55	30 IMPL. DEV. CHARGED TO PAT	627,377	260,993	888,370	.532024	.532024	
56	DRUGS CHARGED TO PATIENTS	2,273,339	2,345,705	4,619,044	.261042	.261042	
57	RENAL DIALYSIS						
58	ASC (NON-DISTINCT PART)						
60	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	328,055	7,155,847	7,483,902	.491482	.491482	
62	OBSERVATION BEDS (NON-DIS		759,213	759,213	1.284019	1.284019	
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC						
64	OTHER REIMBURS COST CNTRS						
64	HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	16,282,585	43,791,651	60,074,236			
102	LESS OBSERVATION BEDS						
103	TOTAL	16,282,585	43,791,651	60,074,236			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
38	OPERATING ROOM	2,148,695	190,398	1,958,297			2,148,695
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO	149,904	51,241	98,663			149,904
41	ANESTHESIOLOGY	51,142	764	50,378			51,142
42	RADIOLOGY-DIAGNOSTIC	2,763,036	170,349	2,592,687			2,763,036
43	RADIOLOGY-THERAPEUTIC						
44	RADIOISOTOPE						
45	LABORATORY	2,808,920	74,174	2,734,746			2,808,920
46	PBP CLINICAL LAB SERVICES						
47	WHOLE BLOOD & PACKED RED						
48	BLOOD STORING, PROCESSING						
49	INTRAVENOUS THERAPY						
50	RESPIRATORY THERAPY	775,269	36,024	739,245			775,269
51	PHYSICAL THERAPY	734,944	65,567	669,377			734,944
52	OCCUPATIONAL THERAPY	202,029	8,999	193,030			202,029
53	SPEECH PATHOLOGY	44,333	7,153	37,180			44,333
54	ELECTROCARDIOLOGY	236,173	2,976	233,197			236,173
55	ELECTROENCEPHALOGRAPHY						
56	MEDICAL SUPPLIES CHARGED	742,583	44,639	697,944			742,583
57	30 IMPL. DEV. CHARGED TO PAT	472,634	5,310	467,324			472,634
58	DRUGS CHARGED TO PATIENTS	1,205,764	30,524	1,175,240			1,205,764
59	RENAL DIALYSIS						
60	ASC (NON-DISTINCT PART)						
61	OUTPAT SERVICE COST CNTRS						
62	CLINIC						
63	EMERGENCY	3,678,203	137,400	3,540,803			3,678,203
64	OBSERVATION BEDS (NON-DIS	974,844		974,844			974,844
65	OTHER OUTPATIENT SERVICE						
66	50 RURAL HEALTH CLINIC						
67	OTHER REIMBURS COST CNTRS						
68	HOME PROGRAM DIALYSIS						
69	AMBULANCE SERVICES						
70	DURABLE MEDICAL EQUIP-REN						
71	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	16,988,473	825,518	16,162,955			16,988,473
102	LESS OBSERVATION BEDS	974,844		974,844			974,844
103	TOTAL	16,013,629	825,518	15,188,111			16,013,629

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	4,424,189	.485670	.485670
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROO	192,720	.777833	.777833
40	ANESTHESIOLOGY	448,474	.114036	.114036
41	RADIOLOGY-DIAGNOSTIC	15,808,620	.174780	.174780
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	13,289,790	.211359	.211359
45	PBP CLINICAL LAB SERVICES			
46	WHOLE BLOOD & PACKED RED			
47	BLOOD STORING, PROCESSING			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	1,362,430	.569034	.569034
50	PHYSICAL THERAPY	1,834,546	.400614	.400614
51	OCCUPATIONAL THERAPY	320,663	.630035	.630035
52	SPEECH PATHOLOGY	9,145	4.847786	4.847786
53	ELECTROCARDIOLOGY	783,320	.301503	.301503
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	2,371,840	.313083	.313083
55	30 IMPL. DEV. CHARGED TO PAT	888,370	.532024	.532024
56	DRUGS CHARGED TO PATIENTS	4,619,044	.261042	.261042
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART)			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	7,483,902	.491482	.491482
62	OBSERVATION BEDS (NON-DIS	759,213	1.284019	1.284019
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-REN			
67	DURABLE MEDICAL EQUIP-SOL			
101	SUBTOTAL	54,596,266		
102	LESS OBSERVATION BEDS	759,213		
103	TOTAL	53,837,053		

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
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	2,148,695	190,398	1,958,297			2,148,695
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO	149,904	51,241	98,663			149,904
40	ANESTHESIOLOGY	51,142	764	50,378			51,142
41	RADIOLOGY-DIAGNOSTIC	2,763,036	170,349	2,592,687			2,763,036
42	RADIOLOGY-THERAPEUTIC						
43	RADIOISOTOPE						
44	LABORATORY	2,808,920	74,174	2,734,746			2,808,920
45	PBP CLINICAL LAB SERVICES						
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	775,269	36,024	739,245			775,269
50	PHYSICAL THERAPY	734,944	65,567	669,377			734,944
51	OCCUPATIONAL THERAPY	202,029	8,999	193,030			202,029
52	SPEECH PATHOLOGY	44,333	7,153	37,180			44,333
53	ELECTROCARDIOLOGY	236,173	2,976	233,197			236,173
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	742,583	44,639	697,944			742,583
55	30 IMPL. DEV. CHARGED TO PAT	472,634	5,310	467,324			472,634
56	DRUGS CHARGED TO PATIENTS	1,205,764	30,524	1,175,240			1,205,764
57	RENAL DIALYSIS						
58	ASC (NON-DISTINCT PART)						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	3,678,203	137,400	3,540,803			3,678,203
62	OBSERVATION BEDS (NON-DIS	974,844		974,844			974,844
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC						
	OTHER REIMBURS COST CNTRS						
64	HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	16,988,473	825,518	16,162,955			16,988,473
102	LESS OBSERVATION BEDS	974,844		974,844			974,844
103	TOTAL	16,013,629	825,518	15,188,111			16,013,629

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	4,424,189	.485670	.485670
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROO	192,720	.777833	.777833
40	ANESTHESIOLOGY	448,474	.114036	.114036
41	RADIOLOGY-DIAGNOSTIC	15,808,620	.174780	.174780
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	13,289,790	.211359	.211359
45	PBP CLINICAL LAB SERVICES			
46	WHOLE BLOOD & PACKED RED			
47	BLOOD STORING, PROCESSING			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	1,362,430	.569034	.569034
50	PHYSICAL THERAPY	1,834,546	.400614	.400614
51	OCCUPATIONAL THERAPY	320,663	.630035	.630035
52	SPEECH PATHOLOGY	9,145	4.847786	4.847786
53	ELECTROCARDIOLOGY	783,320	.301503	.301503
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	2,371,840	.313083	.313083
55	30 IMPL. DEV. CHARGED TO PAT	888,370	.532024	.532024
56	DRUGS CHARGED TO PATIENTS	4,619,044	.261042	.261042
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART)			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	7,483,902	.491482	.491482
62	OBSERVATION BEDS (NON-DIS	759,213	1.284019	1.284019
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-REN			
67	DURABLE MEDICAL EQUIP-SOL			
101	SUBTOTAL	54,596,266		
102	LESS OBSERVATION BEDS	759,213		
103	TOTAL	53,837,053		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS
 I PROVIDER NO: 15-1301 I PERIOD: 7/ 1/2009 I PREPARED 11/24/2010
 I COMPONENT NO: 15-1301 I TO 6/30/2010 I WORKSHEET D
 I I I PART V

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	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
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.485670		.485670		
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM	.777833		.777833		
40 ANESTHESIOLOGY	.114036		.114036		
41 RADIOLOGY-DIAGNOSTIC	.174780		.174780		
42 RADIOLOGY-THERAPEUTIC					
43 RADIOISOTOPE					
44 LABORATORY	.211359		.211359		
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	.569034		.569034		
50 PHYSICAL THERAPY	.400614		.400614		
51 OCCUPATIONAL THERAPY	.630035		.630035		
52 SPEECH PATHOLOGY	4.847786		4.847786		
53 ELECTROCARDIOLOGY	.301503		.301503		
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.313083		.313083		
55 30 IMPL. DEV. CHARGED TO PATIENT	.532024		.532024		
56 DRUGS CHARGED TO PATIENTS	.261042		.261042		
57 RENAL DIALYSIS					
58 ASC (NON-DISTINCT PART)					
60 OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY	.491482		.491482		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.284019		1.284019		
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
64 OTHER REIMBURS COST CNTRS					
64 HOME PROGRAM DIALYSIS					
65 AMBULANCE SERVICES					
66 DURABLE MEDICAL EQUIP-RENTED					
67 DURABLE MEDICAL EQUIP-SOLD					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2010 I PART V
 I 15-1301 I I

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	4 Other Outpatient Diagnostic	5 All Other (1)	6 Outpatient Ambulatory Surgical Ctr	7 Outpatient Radiology	8 Other Outpatient Diagnostic
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		1,214,506			
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY		106,884			
41 RADIOLOGY-DIAGNOSTIC		3,875,745			
42 RADIOLOGY-THERAPEUTIC					
43 RADIOISOTOPE					
44 LABORATORY		3,575,371			
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		368,354			
50 PHYSICAL THERAPY		461,960			
51 OCCUPATIONAL THERAPY		40,300			
52 SPEECH PATHOLOGY		1,602			
53 ELECTROCARDIOLOGY		337,967			
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		486,417			
55 30 IMPL. DEV. CHARGED TO PATIENT		64,556			
56 DRUGS CHARGED TO PATIENTS		698,928			
57 RENAL DIALYSIS					
58 ASC (NON-DISTINCT PART)					
60 OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY		1,571,738			
62 OBSERVATION BEDS (NON-DISTINCT PART)		277,803			
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
64 OTHER REIMBURS COST CNTRS					
64 HOME PROGRAM DIALYSIS					
65 AMBULANCE SERVICES					
66 DURABLE MEDICAL EQUIP-RENTED					
67 DURABLE MEDICAL EQUIP-SOLD					
101 SUBTOTAL		13,082,131			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES		13,082,131			

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2010 I PART V
 I 15-1301 I I

TITLE XVIII, PART B

HOSPITAL

All Other Hospital I/P Hospital I/P
 Part B Charges Part B Charges Part B Costs

Cost Center Description	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM	589,849		
38 RECOVERY ROOM			
39 DELIVERY ROOM & LABOR ROOM			
40 ANESTHESIOLOGY	12,189		
41 RADIOLOGY-DIAGNOSTIC	677,403		
42 RADIOLOGY-THERAPEUTIC			
43 RADIOISOTOPE			
44 LABORATORY	755,687		
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	209,606		
50 PHYSICAL THERAPY	185,068		
51 OCCUPATIONAL THERAPY	25,390		
52 SPEECH PATHOLOGY	7,766		
53 ELECTROCARDIOLOGY	101,898		
54 ELECTROENCEPHALOGRAPHY			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	152,289		
55 30 IMPL. DEV. CHARGED TO PATIENT	34,345		
56 DRUGS CHARGED TO PATIENTS	182,450		
57 RENAL DIALYSIS			
58 ASC (NON-DISTINCT PART)			
60 OUTPAT SERVICE COST CNTRS			
60 CLINIC			
61 EMERGENCY	772,481		
62 OBSERVATION BEDS (NON-DISTINCT PART)	356,704		
63 OTHER OUTPATIENT SERVICE COST CENTER			
63 50 RURAL HEALTH CLINIC			
64 OTHER REIMBURS COST CNTRS			
64 HOME PROGRAM DIALYSIS			
65 AMBULANCE SERVICES			
66 DURABLE MEDICAL EQUIP-RENTED			
67 DURABLE MEDICAL EQUIP-SOLD			
101 SUBTOTAL	4,063,125		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES			
104 NET CHARGES	4,063,125		

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1	.261042
2	PROGRAM VACCINE CHARGES		2,164
3	PROGRAM COSTS		565

COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/24/2010
I	15-1301	I	FROM 7/ 1/2009	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 6/30/2010	I	PART I
I	15-1301	I		I	

TITLE XVIII PART A

HOSPITAL

OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	4,292
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,857
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,857
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	164
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)	140
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	71
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)	60
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,494
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	164
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)	140
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	149.35
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	149.35
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	4,802,976
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	10,604
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	8,961
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	369,037
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,433,939

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	6,198,448
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	6,198,448
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.715331
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,607.06
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	4,433,939

TITLE XVIII PART A HOSPITAL OTHER
 PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 1,149.58
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,717,473
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,717,473

	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					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1,355,237
49 TOTAL PROGRAM INPATIENT COSTS					3,072,710

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) 188,531
 61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) 160,941
 62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS 349,472
 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	848
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,149.58
85	OBSERVATION BED COST	974,844

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 11/24/2010
I	15-1301	I	FROM 7/ 1/2009	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 6/30/2010	I	PART I
I	15-1301	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)	4,292
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,857
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,857
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS)	164
	THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER	140
	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)	71
	THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER	60
	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	523
	(EXCLUDING SWING-BED AND NEWBORN DAYS)	
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)	440
16	NURSERY DAYS (TITLE V OR XIX ONLY)	272

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	149.35
	DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER	149.35
	DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	4,802,976
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	10,604
	REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST	8,961
	REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	369,037
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,433,939

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	6,198,448
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	6,198,448
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.715331
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,607.06
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	4,433,939
	COST DIFFERENTIAL	

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET D-1
 I COMPONENT NO: I TO 6/30/2010 I PART II
 I 15-1301 I I

COMPUTATION OF INPATIENT OPERATING COST

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 1,149.58
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 601,230
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 601,230

	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST
42 NURSERY (TITLE V & XIX ONLY) INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS	663,696	440	1,508.40	272	410,285
43 INTENSIVE CARE UNIT					
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1 419,088
49 TOTAL PROGRAM INPATIENT COSTS					1,430,603

PASS THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

TITLE XIX - I/P HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	848
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,149.58
85	OBSERVATION BED COST	974,844

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET D-4
 I COMPONENT NO: I TO 6/30/2010 I
 I 15-1301 I I

TITLE XVIII, PART A

HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		1,214,527	
26	INTENSIVE CARE UNIT			
27	CORONARY CARE UNIT			
28	BURN INTENSIVE CARE UNIT			
29	SURGICAL INTENSIVE CARE UNIT			
31	SUBPROVIDER			
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.485670	409,826	199,040
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM	.777833	13,478	10,484
40	ANESTHESIOLOGY	.114036	26,622	3,036
41	RADIOLOGY-DIAGNOSTIC	.174780	377,606	65,998
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	.211359	705,242	149,059
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	.569034	516,332	293,810
50	PHYSICAL THERAPY	.400614	101,909	40,826
51	OCCUPATIONAL THERAPY	.630035	38,828	24,463
52	SPEECH PATHOLOGY	4.847786	2,401	11,640
53	ELECTROCARDIOLOGY	.301503	61,758	18,620
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.313083	491,631	153,921
55	30 IMPL. DEV. CHARGED TO PATIENT	.532024	223,906	119,123
56	DRUGS CHARGED TO PATIENTS	.261042	1,015,993	265,217
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART) OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.491482		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.284019		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD			
101	TOTAL		3,985,532	1,355,237
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		3,985,532	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET D-4
 I COMPONENT NO: I TO 6/30/2010 I
 I 15-Z301 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
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
27	CORONARY CARE UNIT			
28	BURN INTENSIVE CARE UNIT			
29	SURGICAL INTENSIVE CARE UNIT			
31	SUBPROVIDER			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.485670	1,816	882
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM	.777833		
40	ANESTHESIOLOGY	.114036		
41	RADIOLOGY-DIAGNOSTIC	.174780	257	45
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	.211359	8,321	1,759
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	.569034	19,242	10,949
50	PHYSICAL THERAPY	.400614	82,425	33,021
51	OCCUPATIONAL THERAPY	.630035	26,151	16,476
52	SPEECH PATHOLOGY	4.847786	573	2,778
53	ELECTROCARDIOLOGY	.301503	369	111
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.313083	36,814	11,526
55	30 IMPL. DEV. CHARGED TO PATIENT	.532024		
56	DRUGS CHARGED TO PATIENTS	.261042	92,735	24,208
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART)			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.491482	507	249
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.284019		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD			
101	TOTAL		269,210	102,004
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		269,210	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET D-4
 I COMPONENT NO: I TO 6/30/2010 I
 I 15-1301 I

TITLE XIX		HOSPITAL	OTHER		
WKST A	COST CENTER DESCRIPTION	RATIO COST	INPATIENT	INPATIENT	
LINE NO.		TO CHARGES	CHARGES	COST	
		1	2	3	
	INPAT ROUTINE SRVC CNTRS				
25	ADULTS & PEDIATRICS		1,233,400		
26	INTENSIVE CARE UNIT				
27	CORONARY CARE UNIT				
28	BURN INTENSIVE CARE UNIT				
29	SURGICAL INTENSIVE CARE UNIT				
31	SUBPROVIDER				
	ANCILLARY SRVC COST CNTRS				
37	OPERATING ROOM	.485670	318,111	154,497	
38	RECOVERY ROOM				
39	DELIVERY ROOM & LABOR ROOM	.777833			
40	ANESTHESIOLOGY	.114036			
41	RADIOLOGY-DIAGNOSTIC	.174780	63,609	11,118	
42	RADIOLOGY-THERAPEUTIC				
43	RADIOISOTOPE				
44	LABORATORY	.211359	317,692	67,147	
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	.569034	115,628	65,796	
50	PHYSICAL THERAPY	.400614	6,510	2,608	
51	OCCUPATIONAL THERAPY	.630035	2,315	1,459	
52	SPEECH PATHOLOGY	4.847786			
53	ELECTROCARDIOLOGY	.301503	6,668	2,010	
54	ELECTROENCEPHALOGRAPHY				
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.313083	93,306	29,213	
55	30 IMPL. DEV. CHARGED TO PATIENT	.532024			
56	DRUGS CHARGED TO PATIENTS	.261042	326,539	85,240	
57	RENAL DIALYSIS				
58	ASC (NON-DISTINCT PART)				
	OUTPAT SERVICE COST CNTRS				
60	CLINIC				
61	EMERGENCY	.491482			
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.284019			
63	OTHER OUTPATIENT SERVICE COST CENTER				
63	50 RURAL HEALTH CLINIC				
	OTHER REIMBURS COST CNTRS				
64	HOME PROGRAM DIALYSIS				
65	AMBULANCE SERVICES				
66	DURABLE MEDICAL EQUIP-RENTED				
67	DURABLE MEDICAL EQUIP-SOLD				
101	TOTAL		1,250,378	419,088	
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES				
103	NET CHARGES		1,250,378		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/24/2010
I	15-1301	I	FROM 7/ 1/2009	I	WORKSHEET E
I	COMPONENT NO:	I	TO 6/30/2010	I	PART B
I	15-1301	I		I	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	4,063,690
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	4,063,690
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	4,104,327
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	CAH DEDUCTIBLES	38,444
18.01	CAH ACTUAL BILLED COINSURANCE	1,910,071
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	2,155,812
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	2,155,812
24	PRIMARY PAYER PAYMENTS	792
25	SUBTOTAL	2,155,020
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	357,277
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	357,277
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	309,191
28	SUBTOTAL	2,512,297
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	2,512,297
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	2,400,545
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	111,752
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	2,515
TO BE COMPLETED BY CONTRACTOR		
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)	
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)	
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY	
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	
54	TOTAL (SUM OF LINES 51 AND 53)	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I	PROVIDER NO:	I	PERIOD:	I	PREPARED
I	15-1301	I	FROM 7/ 1/2009	I	11/24/2010
I	COMPONENT NO:	I	TO 6/30/2010	I	WORKSHEET E-1
I	15-1301	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		2,325,550		2,415,562
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	6/28/2010	235,442	6/28/2010	221,185
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50	2/ 4/2010	87,783	2/ 4/2010	236,202
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		147,659		-15,017
4 TOTAL INTERIM PAYMENTS		2,473,209		2,400,545
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)		356,989		111,752
7 TOTAL MEDICARE PROGRAM LIABILITY		2,830,198		2,512,297

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET E-1
 I COMPONENT NO: I TO 6/30/2010 I
 I 15-Z301 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		403,340		
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	6/10/2010	30,450		
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50	2/ 4/2010	7,350		
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		23,100		NONE
4 TOTAL INTERIM PAYMENTS		426,440		
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)		29,551		
7 TOTAL MEDICARE PROGRAM LIABILITY		455,991		

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
I 15-1301 I FROM 7/ 1/2009 I
I COMPONENT NO: I TO 6/30/2010 I WORKSHEET E-2
I 15-Z301 I

TITLE XVIII

SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A 1	PART B 2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	352,967	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	103,024	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	304	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	455,991	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	455,991	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	455,991	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		
14	80% OF PART B COSTS		
15	SUBTOTAL	455,991	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	455,991	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	426,440	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	29,551	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	366	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/24/2010
I	15-1301	I	FROM 7/ 1/2009	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 6/30/2010	I	PART II
I	15-1301	I		I	

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT
HOSPITAL

1	INPATIENT SERVICES	3,072,710
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	3,072,710
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	3,103,437

COMPUTATION OF LESSER OF COST OR CHARGES

7	REASONABLE CHARGES	
8	ROUTINE SERVICE CHARGES	
9	ANCILLARY SERVICE CHARGES	
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
11	TEACHING PHYSICIANS	
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	3,103,437
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	342,096
21	EXCESS REASONABLE COST	
22	SUBTOTAL	2,761,341
23	COINSURANCE	
24	SUBTOTAL	2,761,341
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	68,857
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	68,857
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	68,857
26	SUBTOTAL	2,830,198
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	2,830,198
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	2,473,209
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	356,989
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	2,238

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS				
2	TEMPORARY INVESTMENTS	4,572,943	146,672		
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE				
5	OTHER RECEIVABLES	2,980,078			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7	INVENTORY	301,613			
8	PREPAID EXPENSES				
9	OTHER CURRENT ASSETS	226,078			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	8,080,712	146,672		
FIXED ASSETS					
12	LAND	721,752			
12.01	LAND IMPROVEMENTS				
13	LAND IMPROVEMENTS				
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	17,950,809			
14.01	LESS ACCUMULATED DEPRECIATION				
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT	5,796,172			
16.01	LESS ACCUMULATED DEPRECIATION	-9,755,971			
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	14,712,762			
OTHER ASSETS					
22	INVESTMENTS	7,271,078			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	203,988			
26	TOTAL OTHER ASSETS	7,475,066			
27	TOTAL ASSETS	30,268,540	146,672		

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	468,912			
29 SALARIES, WAGES & FEES PAYABLE				
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	119,885			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	2,934,280			
36 TOTAL CURRENT LIABILITIES	3,523,077			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	14,738,426			
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES	3,372,308			
42 TOTAL LONG-TERM LIABILITIES	18,110,734			
43 TOTAL LIABILITIES	21,633,811			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	8,634,729			
45 SPECIFIC PURPOSE FUND		146,672		
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	8,634,729	146,672		
52 TOTAL LIABILITIES AND FUND BALANCES	30,268,540	146,672		

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		7,987,145		71,720
2 NET INCOME (LOSS)		329,868		
3 TOTAL		8,317,013		71,720
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 CONTRIBUTIONS			168,861	
6 TRANSFER FROM AFFILIATE	128,212			
7 GRANT REVENUE			81,706	
8 OTHER RESTRICTED ACTIVITY			274,982	
9 REST CONT - PROPERTY, DEF	321,406			
10 TOTAL ADDITIONS		449,618		525,549
11 SUBTOTAL		8,766,631		597,269
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 OTHER UNRESTRICTED ACTIVI	131,902			
14 NET ASSETS RELEASED FROM			450,597	
15				
16				
17				
18 TOTAL DEDUCTIONS		131,902		450,597
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		8,634,729		146,672

	ENDOWMENT FUND		PLANT FUND	
	5	6	7	8
1 FUND BALANCE AT BEGINNING OF PERIOD				
2 NET INCOME (LOSS)				
3 TOTAL				
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 CONTRIBUTIONS				
6 TRANSFER FROM AFFILIATE				
7 GRANT REVENUE				
8 OTHER RESTRICTED ACTIVITY				
9 REST CONT - PROPERTY, DEF				
10 TOTAL ADDITIONS				
11 SUBTOTAL				
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 OTHER UNRESTRICTED ACTIVI				
14 NET ASSETS RELEASED FROM				
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 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET G-2
 I I TO 6/30/2010 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	6,198,448		6,198,448
2 00 SUBPROVIDER			
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
6 00 SKILLED NURSING FACILITY			
7 00 NURSING FACILITY			
7 01 ICF/MR			
8 00 OTHER LONG TERM CARE			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	6,198,448		6,198,448
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT			
11 00 CORONARY CARE UNIT			
12 00 BURN INTENSIVE CARE UNIT			
13 00 SURGICAL INTENSIVE CARE UNIT			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	6,198,448		6,198,448
17 00 ANCILLARY SERVICES	10,996,548	46,804,149	57,800,697
18 00 OUTPATIENT SERVICES			
18 50 RURAL HEALTH CLINIC			
19 00 HOME HEALTH AGENCY			
20 00 AMBULANCE SERVICES			
21 00 CORF			
22 00 AMBULATORY SURGICAL CENTER (D.P.)			
23 00 HOSPICE			
24 00			
25 00 TOTAL PATIENT REVENUES	17,194,996	46,804,149	63,999,145

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		24,445,970	
ADD (SPECIFY)			
27 00 BAD DEBTS	2,391,859		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		2,391,859	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		26,837,829	

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2010
 I 15-1301 I FROM 7/ 1/2009 I WORKSHEET G-3
 I I TO 6/30/2010 I

DESCRIPTION

ALL PATIENT REVENUES	63,999,145
LESS: ALLOWANCES AND DISCOUNTS ON PATIENT REVENUES	37,972,063
LESS: TOTAL OPERATING EXPENSES	26,027,082
INCOME FROM SERVICE TO PATIENT CENTER INCOME	26,837,829
CONTRIBUTIONS, DONATIONS, BEQUESTS INCOME FROM INVESTMENTS	-810,747
REVENUE FROM TELEPHONE AND TELEVISION AND RADIO PURCHASE DISCOUNTS	
REBATES AND REFUNDS OF EXPENSES	
PARKING LOT RECEIPTS	
REVENUE FROM LAUNDRY AND LINEN SERVICE	
REVENUE FROM MEALS SOLD TO EMPLOYEES	
REVENUE FROM RENTAL OF LIVING QUARTERS	
REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES OTHER THAN PATIENTS	
REVENUE FROM SALE OF DRUGS TO OUTPATIENTS	
REVENUE FROM SALE OF MEDICAL RECORDS	
REVENUE FROM SALES OF TEXTBOOKS	
REVENUE FROM GIFTS, FLOWERS, COFFEES	
RENTAL OF VENDING MACHINES	
RENTAL OF HOSPITAL SPACE	
GOVERNMENTAL APPROPRIATIONS	
PHYSICIAN INCOME	516,019
REIMBURSABLE COST CENTERS	
INTEREST INCOME	370,376
REALIZED GAIN - SHORT TERM	254,220
ALL OTHER INCOME	1,140,615
LESS: OPERATING EXPENSES (SPECIFY)	329,868
LESS: OTHER EXPENSES	
NET INCOME (OR LOSS) FOR THE PERIOD	329,868