

**ST. VINCENT SALEM HOSPITAL
SALEM, INDIANA**

PROVIDER NOS. 15-1314, 15-M314 AND 15-Z314

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

February 1, 2010 to June 30, 2010

ST. VINCENT SALEM HOSPITAL
PROVIDER NOS. 15-1314, 15-M314 AND 15-Z314

TABLE OF CONTENTS

Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Board of Trustees
St. Vincent Salem Hospital
Salem, Indiana

In accordance with your request, we have compiled the Hospital Statements of Reimbursable Costs (Titles XVIII and XIX) of St. Vincent Salem Hospital (Provider Nos. 15-1314, 15-M314 and 15-Z314) for the period 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 financial information is intended to be filed with the Centers for Medicare and Medicaid Services and should not be used for any other purpose.

Bradley Associates, Inc.

November 23, 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 5
 PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	I	15-1314	I	FROM 2/ 1/2010	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 6/30/2010	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 11/22/2010 TIME 16:11

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 SALEM 15-1314

FOR THE COST REPORTING PERIOD BEGINNING 2/ 1/2010 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: 11/22/2010 TIME 16:11

.9o04Nzzw3GaB05MA698nTEu46oUg0
 fKtnq08VB1lZ4sqafEXaBKieYu.oKo
 mhmf0Gv7my0ddqLV8

 PI ENCRYPTION INFORMATION
 DATE: 11/22/2010 TIME 16:11

shmjbhm6sAfnxxB:hjsj1ZAZmIAC00
 v12ga0Hce1NwQj8XKEG.CO5rcEN:6w
 g67H24jImZ0PPbas

 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	317,975	351,571	0
3	SWING BED - SNF	0	85,974	0	0
100	TOTAL	0	403,949	351,571	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.

MCRIF32 1.22.0.0 ~ 2552-96 22.0.122.3

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET S-2
 I I TO 6/30/2010 I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 911 N. SHELBY ST.
 1.01 CITY: SALEM

P.O. BOX:
 STATE: IN ZIP CODE: 47167- COUNTY: WASHINGTON

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
0	1	2	2.01	3	4	5	6
02.00 HOSPITAL	ST VINCENT SALEM	15-1314		12/ 1/2002	N	0	N
04.00 SWING BED - SNF	ST VINCENT SALEM	15-2314		12/ 1/2002	N	0	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 2/ 1/2010 TO: 6/30/2010

18 TYPE OF CONTROL

1 2
 2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL
 20 SUBPROVIDER

1

OTHER INFORMATION

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

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

N N

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

21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.

Y 31140

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.

2 N

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER?

N

23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW.

N

23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.

/ / / /

23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.

/ / / /

23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.

/ / / /

23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.

/ / / /

23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.

/ / / /

23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.

/ / / /

23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.

/ / / /

24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY)

/ /

24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy).

/ /

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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 12/ 1/2002

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
0 0.0000 0.0000

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

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

28.03 STAFFING % 0.00% Y/N

28.04 RECRUITMENT 0.00%

28.05 RETENTION 0.00%

28.06 TRAINING 0.00%

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

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

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

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

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

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

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

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

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

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

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

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

MISCELLANEOUS COST REPORT INFORMATION

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

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

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

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

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

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

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

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET 5-2
 I I TO 6/30/2010 I

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

TITLE XIX INPATIENT SERVICES

38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y
 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? 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 15H046
 40.01 NAME: ST VINCENT HEALTH FI/CONTRACTOR NAME NATIONAL GOVERNMENT SERVICES FI/CONTRACTOR #
 40.02 STREET: 10330 N. MERIDIAN STREET 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? N
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?
 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?
 46 IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

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

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

52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N
 52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV N
 53 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0
 53.01 MDH PERIOD: BEGINNING: / / ENDING: / /

54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
 PREMIUMS: 0
 PAID LOSSES: 0
 AND/OR SELF INSURANCE: 0

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

	DATE	Y OR N	LIMIT	Y OR N	FEES
	0	1	2	3	4
56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002. N 0.00 0					
56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE. 0.00 0					
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY. 0.00 0					
56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY. 0.00 0					

- 57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N
- 58 ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. N
- 58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).
- 59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N
- 60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N
- 60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(c)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC). 0

MULTICAMPUS

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

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

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00

SETTLEMENT DATA

- 63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). Y 9/14/2010

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
I 15-1314 I FROM 2/ 1/2010 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	TITLE V 3	I/P DAYS / TITLE XVIII 4	O/P VISITS / NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1 ADULTS & PEDIATRICS	25	3,750	15,696.00			437	58
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF						175	
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	25	3,750	15,696.00			612	58
6 INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL	25	3,750	15,696.00			612	58
13 RPCH VISITS							
14 SUBPROVIDER							
15 SKILLED NURSING FACILITY							
18 HOME HEALTH AGENCY							
21 HOSPICE							
25 TOTAL	25						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	TITLE XIX ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	/ TRIPS TOTAL OBSERVATION BEDS ADMITTED 6.01	OBSERVATION BEDS NOT ADMITTED 6.02	INTERNS & RES. TOTAL 7	FTES LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			652				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			175				
4 ADULTS & PED-SB NF			40				
5 TOTAL ADULTS AND PEDS			867				
6 INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL			867				
13 RPCH VISITS							
14 SUBPROVIDER							
15 SKILLED NURSING FACILITY							
18 HOME HEALTH AGENCY							
21 HOSPICE							
25 TOTAL			111				
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS			2				
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	I & R FTES NET 9	--- FULL TIME EQUIV EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS					144	17	252
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
6 INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL		145.97			144	17	252
13 RPCH VISITS							
14 SUBPROVIDER							
15 SKILLED NURSING FACILITY							
18 HOME HEALTH AGENCY							
21 HOSPICE							
25 TOTAL		145.97					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET A
 I I TO 6/30/2010 I

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

	COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		182,903	182,903		182,903
4	0400	NEW CAP REL COSTS-MVBLE EQUIP					
5	0500	EMPLOYEE BENEFITS	155,963	717,148	873,111		873,111
6	0600	ADMINISTRATIVE & GENERAL	424,895	644,239	1,069,134	-2,917	1,066,217
8	0800	OPERATION OF PLANT	73,138	481,893	555,031		555,031
9	0900	LAUNDRY & LINEN SERVICE					
10	1000	HOUSEKEEPING	57,857	18,878	76,735	-1,135	75,600
11	1100	DIETARY	80,125	37,773	117,898	-94,430	23,468
12	1200	CAFETERIA				93,300	93,300
14	1400	NURSING ADMINISTRATION	30,877	625	31,502	-1,031	30,471
15	1500	CENTRAL SERVICES & SUPPLY	35,844	5,958	41,802	-1,144	40,658
16	1600	PHARMACY	76,445	178,067	254,512	-146,688	107,824
17	1700	MEDICAL RECORDS & LIBRARY	103,247	2,633	105,880		105,880
18	1800	SOCIAL SERVICE					
20	2000	NONPHYSICIAN ANESTHETISTS					
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	325,603	44,447	370,050	-12,601	357,449
26	2600	INTENSIVE CARE UNIT					
31	3100	SUBPROVIDER					
33	3300	NURSERY					
34	3400	SKILLED NURSING FACILITY					
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	251,797	425,736	677,533	-250,370	427,163
38	3800	RECOVERY ROOM					
39	3900	DELIVERY ROOM & LABOR ROOM					
40	4000	ANESTHESIOLOGY					
41	4100	RADIOLOGY-DIAGNOSTIC	254,382	248,183	502,565	-7,455	495,110
42	4200	RADIOLOGY-THERAPEUTIC					
44	4400	LABORATORY	169,114	324,841	493,955	-3,267	490,688
46	4600	WHOLE BLOOD & PACKED RED BLOOD CELLS					
47	4700	BLOOD STORING, PROCESSING & TRANS.					
48	4800	INTRAVENOUS THERAPY					
49	4900	RESPIRATORY THERAPY	94,463	8,799	103,262	-527	102,735
50	5000	PHYSICAL THERAPY	144,299	5,659	149,958	-2,573	147,385
51	5100	OCCUPATIONAL THERAPY					
52	5200	SPEECH PATHOLOGY					
53	5300	ELECTROCARDIOLOGY	80,880	4,324	85,204	-1,794	83,410
54	5400	ELECTROENCEPHALOGRAPHY					
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS				64,264	64,264
55.30	5530	IMPL. DEV. CHARGED TO PATIENT				216,552	216,552
56	5600	DRUGS CHARGED TO PATIENTS				161,290	161,290
57	5700	RENAL DIALYSIS					
58	5800	ASC (NON-DISTINCT PART)					
59	0000	O/P PSYCH	11,305	168	11,473		11,473
59.01	3950	SLEEP LAB	56,449	29,221	85,670	-1,412	84,258
		OUTPAT SERVICE COST CNTRS					
60	6000	CLINIC					
61	6100	EMERGENCY	653,896	64,540	718,436	-11,175	707,261
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
		OTHER REIMBURS COST CNTRS					
64	6400	HOME PROGRAM DIALYSIS					
65	6500	AMBULANCE SERVICES					
70	7000	I&R SERVICES-NOT APPRVD PRGM					
71	7100	HOME HEALTH AGENCY					
		SPEC PURPOSE COST CENTERS					
88	8800	INTEREST EXPENSE					
93	9300	HOSPICE					
95		SUBTOTALS	3,080,579	3,426,035	6,506,614	-3,113	6,503,501
		NONREIMBURS COST CENTERS					
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
97	9700	RESEARCH					
98	9800	PHYSICIANS' PRIVATE OFFICES	26,790	9,094	35,884	-129	35,755
99	9900	NONPAID WORKERS					
100	0000	PUBLIC RELATIONS	22,831	4,991	27,822	3,242	31,064
101		TOTAL	3,130,200	3,440,120	6,570,320	-0-	6,570,320

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
I 15-1314 I FROM 2/ 1/2010 I WORKSHEET A
I I TO 6/30/2010 I

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
			6	7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT	97,380	280,283
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		
5	0500	EMPLOYEE BENEFITS	104,651	977,762
6	0600	ADMINISTRATIVE & GENERAL	880,933	1,947,150
8	0800	OPERATION OF PLANT	-12,021	543,010
9	0900	LAUNDRY & LINEN SERVICE		
10	1000	HOUSEKEEPING		75,600
11	1100	DIETARY		23,468
12	1200	CAFETERIA	-27,964	65,336
14	1400	NURSING ADMINISTRATION		30,471
15	1500	CENTRAL SERVICES & SUPPLY		40,658
16	1600	PHARMACY		107,824
17	1700	MEDICAL RECORDS & LIBRARY	-3,198	102,682
18	1800	SOCIAL SERVICE		
20	2000	NONPHYSICIAN ANESTHETISTS		
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS	-3,600	353,849
26	2600	INTENSIVE CARE UNIT		
31	3100	SUBPROVIDER		
33	3300	NURSERY		
34	3400	SKILLED NURSING FACILITY		
		ANCILLARY SRVC COST CNTRS		
37	3700	OPERATING ROOM	-19,537	407,626
38	3800	RECOVERY ROOM		
39	3900	DELIVERY ROOM & LABOR ROOM		
40	4000	ANESTHESIOLOGY		
41	4100	RADIOLOGY-DIAGNOSTIC	-51,758	443,352
42	4200	RADIOLOGY-THERAPEUTIC		
44	4400	LABORATORY		490,688
46	4600	WHOLE BLOOD & PACKED RED BLOOD CELLS		
47	4700	BLOOD STORING, PROCESSING & TRANS.		
48	4800	INTRAVENOUS THERAPY		
49	4900	RESPIRATORY THERAPY		102,735
50	5000	PHYSICAL THERAPY		147,385
51	5100	OCCUPATIONAL THERAPY		
52	5200	SPEECH PATHOLOGY		
53	5300	ELECTROCARDIOLOGY		83,410
54	5400	ELECTROENCEPHALOGRAPHY		
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		64,264
55.30	5530	IMPL. DEV. CHARGED TO PATIENT		216,552
56	5600	DRUGS CHARGED TO PATIENTS		161,290
57	5700	RENAL DIALYSIS		
58	5800	ASC (NON-DISTINCT PART)		
59	0000	O/P PSYCH		11,473
59.01	3950	SLEEP LAB	-22,990	61,268
		OUTPAT SERVICE COST CNTRS		
60	6000	CLINIC		
61	6100	EMERGENCY	-222,397	484,864
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
		OTHER REIMBURS COST CNTRS		
64	6400	HOME PROGRAM DIALYSIS		
65	6500	AMBULANCE SERVICES		
70	7000	I&R SERVICES-NOT APPRVD PRGM		
71	7100	HOME HEALTH AGENCY		
		SPEC PURPOSE COST CENTERS		
88	8800	INTEREST EXPENSE		-0-
93	9300	HOSPICE		
95		SUBTOTALS	719,499	7,223,000
		NONREIMBURS COST CENTERS		
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
97	9700	RESEARCH		
98	9800	PHYSICIANS' PRIVATE OFFICES		35,755
99	9900	NONPAID WORKERS		
100	0000	PUBLIC RELATIONS	113,311	144,375
101		TOTAL	832,810	7,403,130

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I NOT A CMS WORKSHEET
 I I TO 6/30/2010 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
20	NONPHYSICIAN ANESTHETISTS	2000	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
31	SUBPROVIDER	3100	
33	NURSERY	3300	
34	SKILLED NURSING FACILITY	3400	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
38	RECOVERY ROOM	3800	
39	DELIVERY ROOM & LABOR ROOM	3900	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
42	RADIOLOGY-THERAPEUTIC	4200	
44	LABORATORY	4400	
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	
59	O/P PSYCH	0000	
59.01	SLEEP LAB	3950	OTHER ANCILLARY SERVICE COST CENTERS
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	OTHER REIMBURS COST		
64	HOME PROGRAM DIALYSIS	6400	
65	AMBULANCE SERVICES	6500	
70	I&R SERVICES-NOT APPRVD PRGM	7000	
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
93	HOSPICE	9300	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
97	RESEARCH	9700	
98	PHYSICIANS' PRIVATE OFFICES	9800	
99	NONPAID WORKERS	9900	
100	PUBLIC RELATIONS	0000	
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED 11/22/2010
151314	FROM 2/ 1/2010	WORKSHEET A-6
	TO 6/30/2010	

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 2	INCREASE		SALARY 4	OTHER 5
			LINE NO 3			
1 MARKETING	A	PUBLIC RELATIONS	100			3,242
2						
3						
4 MEDICAL SUPPLIES	B	MEDICAL SUPPLIES CHARGED TO PATIENTS	55			64,264
5		IMPL. DEV. CHARGED TO PATIENT	55.30			216,552
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21 CAFETERIA	C	CAFETERIA	12		63,408	29,892
22 DRUGS	D	DRUGS CHARGED TO PATIENTS	56			161,290
23						
24						
25						
26						
27						
28						
29						
30						
31						
36 TOTAL RECLASSIFICATIONS					63,408	475,240

(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:
151314

PERIOD:
FROM 2/ 1/2010
TO 6/30/2010

PREPARED 11/22/2010
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 6	DECREASE		SALARY 8	OTHER 9	A-7 REF 10
			LINE NO 7				
1 MARKETING	A		6			2,907	
2			11			135	
3			53			200	
4 MEDICAL SUPPLIES	B		10			1,135	
5			11			728	
6			15			1,144	
7			16			40	
8			25			10,776	
9			37			32,258	
10			41			496	
11			44			1,485	
12			49			527	
13			50			2,217	
14			53			1,594	
15			59.01			1,407	
16			61			10,319	
17			6			10	
18			98			129	
19			37			215,351	
20			44			1,200	
21 CAFETERIA	C		11		63,408	29,892	
22 DRUGS	D		11			267	
23			14			1,031	
24			16			146,648	
25			25			1,825	
26			37			2,761	
27			41			6,959	
28			44			582	
29			50			356	
30			59.01			5	
31			61			856	
36 TOTAL RECLASSIFICATIONS					63,408	475,240	

(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: 151314	PERIOD: FROM 2/ 1/2010 TO 6/30/2010	PREPARED 11/22/2010 WORKSHEET A-6 NOT A CMS WORKSHEET
------------------------	---	---

RECLASS CODE: A
EXPLANATION : MARKETING

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	PUBLIC RELATIONS	100	3,242	ADMINISTRATIVE & GENERAL	6	2,907	
2.00			0	DIETARY	11	135	
3.00			0	ELECTROCARDIOLOGY	53	200	
TOTAL RECLASSIFICATIONS FOR CODE A			3,242	3,242			

RECLASS CODE: B
EXPLANATION : MEDICAL SUPPLIES

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	64,264	HOUSEKEEPING	10	1,135	
2.00	IMPL. DEV. CHARGED TO PATIENT	55.30	216,552	DIETARY	11	728	
3.00			0	CENTRAL SERVICES & SUPPLY	15	1,144	
4.00			0	PHARMACY	16	40	
5.00			0	ADULTS & PEDIATRICS	25	10,776	
6.00			0	OPERATING ROOM	37	32,258	
7.00			0	RADIOLOGY-DIAGNOSTIC	41	496	
8.00			0	LABORATORY	44	1,485	
9.00			0	RESPIRATORY THERAPY	49	527	
10.00			0	PHYSICAL THERAPY	50	2,217	
11.00			0	ELECTROCARDIOLOGY	53	1,594	
12.00			0	SLEEP LAB	59.01	1,407	
13.00			0	EMERGENCY	61	10,319	
14.00			0	ADMINISTRATIVE & GENERAL	6	10	
15.00			0	PHYSICIANS' PRIVATE OFFICES	98	129	
16.00			0	OPERATING ROOM	37	215,351	
17.00			0	LABORATORY	44	1,200	
TOTAL RECLASSIFICATIONS FOR CODE B			280,816	280,816			

RECLASS CODE: C
EXPLANATION : CAFETERIA

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	CAFETERIA	12	93,300	DIETARY	11	93,300	
TOTAL RECLASSIFICATIONS FOR CODE C			93,300	93,300			

RECLASS CODE: D
EXPLANATION : DRUGS

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	DRUGS CHARGED TO PATIENTS	56	161,290	DIETARY	11	267	
2.00			0	NURSING ADMINISTRATION	14	1,031	
3.00			0	PHARMACY	16	146,648	
4.00			0	ADULTS & PEDIATRICS	25	1,825	
5.00			0	OPERATING ROOM	37	2,761	
6.00			0	RADIOLOGY-DIAGNOSTIC	41	6,959	
7.00			0	LABORATORY	44	582	
8.00			0	PHYSICAL THERAPY	50	356	
9.00			0	SLEEP LAB	59.01	5	
10.00			0	EMERGENCY	61	856	
TOTAL RECLASSIFICATIONS FOR CODE D			161,290	161,290			

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
			DONATION 3					
1 LAND	239,214					239,214		
2 LAND IMPROVEMENTS	307,021					307,021		
3 BUILDINGS & FIXTURE	11,289,789					11,218,896	70,893	
4 BUILDING IMPROVEMEN								
5 FIXED EQUIPMENT	3,752,368					3,752,368		
6 MOVABLE EQUIPMENT	11,824,883					11,678,053	146,830	
7 SUBTOTAL	27,413,275					27,195,552	217,723	
8 RECONCILING ITEMS								
9 TOTAL	27,413,275					27,195,552	217,723	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL	
		GROSS ASSETS	CAPITIALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES		OTHER CAPITAL RELATED COSTS
		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	70,893		70,893	.325611				
4	NEW CAP REL COSTS-MV	146,830		146,830	.674389				
5	TOTAL	217,723		217,723	1.000000				

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL					OTHER CAPITAL RELATED COST	TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES		
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	97,380	174,203		8,700			280,283
4	NEW CAP REL COSTS-MV							
5	TOTAL	97,380	174,203		8,700			280,283

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	TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES		
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL		174,203		8,700			182,903
4	NEW CAP REL COSTS-MV							
5	TOTAL		174,203		8,700			182,903

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

ADJUSTMENTS TO EXPENSES

IN LIEU OF FORM CMS-2552-96(05/1999)
 I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET A-8
 I I TO 6/30/2010 I

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST. A-7 REF. 5
			COST CENTER	LINE NO	
	1	2	3	4	
1			**COST CENTER DELETED**	1	
2			**COST CENTER DELETED**	2	
3			NEW CAP REL COSTS-BLDG &	3	
4			NEW CAP REL COSTS-MVBLE E	4	
5					
6					
7					
8					
9					
10					
11					
12	A-8-2	-320,282			
13					
14	A-8-1	1,185,686			
15					
16	B	-27,964	CAFETERIA	12	
17					
18					
19					
20	B	-3,198	MEDICAL RECORDS & LIBRARY	17	
21					
22					
23					
24					
25	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	A-8-3				
28			**COST CENTER DELETED**	89	
29			**COST CENTER DELETED**	1	
30			**COST CENTER DELETED**	2	
31			NEW CAP REL COSTS-BLDG &	3	
32			NEW CAP REL COSTS-MVBLE E	4	
33			NONPHYSICIAN ANESTHETISTS	20	
34					
35	A-8-4		OCCUPATIONAL THERAPY	51	
36	A-8-4		SPEECH PATHOLOGY	52	
37	B	-810	ADMINISTRATIVE & GENERAL	6	
38	A	-622	ADMINISTRATIVE & GENERAL	6	
39					
40					
41					
42					
43					
44					
45					
46					
47					
48					
49					
50		832,810			

(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	5	EMPLOYEE BENEFITS	SVH - SELF INSURANCE	464,636	359,985	104,651	
2	3	NEW CAP REL COSTS-BLDG &	SVH - CAPITAL	97,380		97,380	9
3	100	PUBLIC RELATIONS	SVH - MARKETING	113,311		113,311	
4	6	ADMINISTRATIVE & GENERAL	SVH - NON-CAPITAL	882,365		882,365	
4.01	5	EMPLOYEE BENEFITS	DIRECT CHARGEBACKS- BENEF	929	929		
4.02	41	RADIOLOGY-DIAGNOSTIC	DIRECT CHARGEBACKS-RADIOL	2,505	2,505		
4.03	61	EMERGENCY	DIRECT CHARGEBACKS-EMERGE	11,672	11,672		
4.04	100	PUBLIC RELATIONS	DIRECT CHARGEBACKS-MARKET	403	403		
4.05	8	OPERATION OF PLANT	ASCENSION - TRIMEDX	147,728	159,749	-12,021	
5		TOTALS		1,720,929	535,243	1,185,686	

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

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

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

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
1	G	100.00	ASCENSION HEALTH	100.00	HOME OFFICE
2	G	100.00	ST VINCENT HEALTH	100.00	HOME OFFICE
3	G	100.00	CATHOLIC HEALTHCARE AUDIT	100.00	HOME OFFICE
4		0.00		0.00	
5		0.00		0.00	

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

IN LIEU OF FORM CMS-2552-96(9/1996)
 I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET A-8-2
 I I TO 6/30/2010 I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	25 MED SURG	3,600	3,600					
2	37 SURGERY	21,737	19,537	2,200				
3	41 RADIOLOGY	54,078	51,758	2,320				
4	59 1 SLEEP DISORDERS	22,990	22,990					
5	61 ER	380,155	222,397	157,758				
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	482,560	320,282	162,278				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 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 25	MED SURG							3,600
2 37	SURGERY							19,537
3 41	RADIOLOGY							51,758
4 59	1 SLEEP DISORDERS							22,990
5 61	ER							222,397
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							320,282

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I NOT A CMS WORKSHEET
 I I TO 6/30/2010 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR	VALUE	NOT ENTERED
5	EMPLOYEE BENEFITS	5	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	3	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	9	HOURS OF	SERVICE	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	11	MEALS	SERVED	ENTERED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	UNITS		ENTERED
16	PHARMACY	15	COSTED	REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	REVENUE		ENTERED
18	SOCIAL SERVICE	17	TIME	SPENT	NOT ENTERED
20	NONPHYSICIAN ANESTHETISTS	18	ASSIGNED	TIME	NOT ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG & OSTS-MVBLE	NEW CAP REL C OSTS-MVBLE	EMPLOYEE BENEFITS	SUBTOTAL	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT
	0	3	4	5	5a.00	6	8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG & NEW CAP REL COSTS-MVBLE E	280,283	280,283					
005 EMPLOYEE BENEFITS	977,762			977,762			
006 ADMINISTRATIVE & GENERAL	1,947,150	46,208		139,682	2,133,040	2,133,040	
008 OPERATION OF PLANT	543,010	17,871		24,044	584,925	236,745	821,670
009 LAUNDRY & LINEN SERVICE		8,029			8,029	3,250	30,514
010 HOUSEKEEPING	75,600	1,164		19,020	95,784	38,768	4,423
011 DIETARY	23,468	23,242		5,496	52,206	21,130	88,329
012 CAFETERIA	65,336			20,845	86,181	34,881	
014 NURSING ADMINISTRATION	30,471	812		10,151	41,434	16,770	3,085
015 CENTRAL SERVICES & SUPPLY	40,658	6,643		11,783	59,084	23,914	25,245
016 PHARMACY	107,824			25,131	132,955	53,813	
017 MEDICAL RECORDS & LIBRARY	102,682	4,070		33,942	140,694	56,945	15,468
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	353,849	37,650		107,040	498,539	201,781	143,088
031 INTENSIVE CARE UNIT							
033 SUBPROVIDER							
034 NURSERY							
037 SKILLED NURSING FACILITY							
038 ANCILLARY SRVC COST CNTRS							
039 OPERATING ROOM	407,626	34,388		82,777	524,791	212,407	130,690
040 RECOVERY ROOM							
041 DELIVERY ROOM & LABOR ROO							
042 ANESTHESIOLOGY							
044 RADIOLOGY-DIAGNOSTIC	443,352	18,660		83,627	545,639	220,845	70,917
046 RADIOLOGY-THERAPEUTIC							
047 LABORATORY	490,688	7,851		55,595	554,134	224,283	29,837
048 WHOLE BLOOD & PACKED RED							
049 BLOOD STORING, PROCESSING							
050 INTRAVENOUS THERAPY							
051 RESPIRATORY THERAPY	102,735			31,054	133,789	54,150	
052 PHYSICAL THERAPY	147,385	6,832		47,437	201,654	81,618	25,963
053 OCCUPATIONAL THERAPY							
054 SPEECH PATHOLOGY							
055 ELECTROCARDIOLOGY	83,410	10,294		26,589	120,293	48,688	39,121
056 ELECTROENCEPHALOGRAPHY							
057 MEDICAL SUPPLIES CHARGED	64,264				64,264	26,011	
058 30 IMPL. DEV. CHARGED TO PAT	216,552				216,552	87,648	
059 DRUGS CHARGED TO PATIENTS	161,290	393			161,683	65,440	1,493
060 RENAL DIALYSIS							
061 ASC (NON-DISTINCT PART)							
062 O/P PSYCH	11,473	3,080		3,716	18,269	7,394	11,707
063 01 SLEEP LAB	61,268			18,557	79,825	32,309	
064 OUTPAT SERVICE COST CNTRS							
065 CLINIC							
066 EMERGENCY	484,864	16,992		214,963	716,819	290,128	64,577
067 OBSERVATION BEDS (NON-DIS							
068 OTHER REIMBURS COST CNTRS							
069 HOME PROGRAM DIALYSIS							
070 AMBULANCE SERVICES							
071 I&R SERVICES-NOT APPRVD P							
072 HOME HEALTH AGENCY							
073 SPEC PURPOSE COST CENTERS							
074 HOSPICE							
075 SUBTOTALS	7,223,000	244,179		961,449	7,170,583	2,038,918	684,457
076 NONREIMBURS COST CENTERS							
077 GIFT, FLOWER, COFFEE SHOP		960			960	389	3,649
078 RESEARCH							
079 PHYSICIANS' PRIVATE OFFIC	35,755	31,956		8,807	76,518	30,970	121,449
080 NONPAID WORKERS							
081 PUBLIC RELATIONS	144,375	3,188		7,506	155,069	62,763	12,115
082 CROSS FOOT ADJUSTMENT							
083 NEGATIVE COST CENTER							
084 TOTAL	7,403,130	280,283		977,762	7,403,130	2,133,040	821,670

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	LAUNDRY & LIN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	CENTRAL SERVI CES & SUPPLY	PHARMACY
	9	10	11	12	14	15	16
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE	41,793						
011 HOUSEKEEPING	270	139,245					
012 DIETARY	2,191		163,856				
014 CAFETERIA		936		121,998			
015 NURSING ADMINISTRATION				2,136	63,425		
016 CENTRAL SERVICES & SUPPLY		1,872		3,209		113,324	
017 PHARMACY				2,434			189,202
018 MEDICAL RECORDS & LIBRARY		3,182		8,880			
020 SOCIAL SERVICE							
025 NONPHYSICIAN ANESTHETISTS							
026 INPAT ROUTINE SRVC CNTRS							
031 ADULTS & PEDIATRICS	11,951	32,753	163,856	21,091	13,123		
033 INTENSIVE CARE UNIT							
034 SUBPROVIDER							
037 NURSERY							
038 SKILLED NURSING FACILITY							
039 ANCILLARY SRVC COST CNTRS							
041 OPERATING ROOM	5,550	41,173		12,358	10,935		
042 RECOVERY ROOM							
044 DELIVERY ROOM & LABOR ROO							
046 ANESTHESIOLOGY							
047 RADIOLOGY-DIAGNOSTIC	4,127	7,112		15,151	10,935		
048 RADIOLOGY-THERAPEUTIC							
049 LABORATORY		5,802		10,020	2,187		
050 WHOLE BLOOD & PACKED RED							
051 BLOOD STORING, PROCESSING							
052 INTRAVENOUS THERAPY							
053 RESPIRATORY THERAPY					5,468		
054 PHYSICAL THERAPY	3,375	4,305		6,917	4,374		
055 OCCUPATIONAL THERAPY							
056 SPEECH PATHOLOGY							
057 ELECTROCARDIOLOGY	2,618	6,176		14,576	4,374		
058 ELECTROENCEPHALOGRAPHY							
059 MEDICAL SUPPLIES CHARGED						110,786	
060 30 IMPL. DEV. CHARGED TO PAT						2,538	
061 DRUGS CHARGED TO PATIENTS		2,433			1,094		189,202
062 RENAL DIALYSIS							
064 ASC (NON-DISTINCT PART)							
065 O/P PSYCH		936		730			
066 01 SLEEP LAB		3,369					
067 OUTPAT SERVICE COST CNTRS							
068 CLINIC							
069 EMERGENCY	11,711	24,143		20,864	10,935		
070 OBSERVATION BEDS (NON-DIS							
071 OTHER REIMBURS COST CNTRS							
072 HOME PROGRAM DIALYSIS							
073 AMBULANCE SERVICES							
074 I&R SERVICES-NOT APPRVD P							
075 HOME HEALTH AGENCY							
076 SPEC PURPOSE COST CENTERS							
077 HOSPICE							
078 SUBTOTALS	41,793	134,192	163,856	118,366	63,425	113,324	189,202
079 NONREIMBURS COST CENTERS							
080 GIFT, FLOWER, COFFEE SHOP		1,123					
081 RESEARCH							
082 PHYSICIANS' PRIVATE OFFIC		3,930		2,386			
083 NONPAID WORKERS							
084 PUBLIC RELATIONS				1,246			
085 CROSS FOOT ADJUSTMENT							
086 NEGATIVE COST CENTER							
087 TOTAL	41,793	139,245	163,856	121,998	63,425	113,324	189,202

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	17	18	20	25	26	27
GENERAL SERVICE COST CNTR						
003 NEW CAP REL COSTS-BLDG &						
004 NEW CAP REL COSTS-MVBLE E						
005 EMPLOYEE BENEFITS						
006 ADMINISTRATIVE & GENERAL						
008 OPERATION OF PLANT						
009 LAUNDRY & LINEN SERVICE						
010 HOUSEKEEPING						
011 DIETARY						
012 CAFETERIA						
014 NURSING ADMINISTRATION						
015 CENTRAL SERVICES & SUPPLY						
016 PHARMACY						
017 MEDICAL RECORDS & LIBRARY	225,169					
018 SOCIAL SERVICE						
020 NONPHYSICIAN ANESTHETISTS						
025 INPAT ROUTINE SRVC CNTRS						
025 ADULTS & PEDIATRICS	15,809			1,101,991		1,101,991
026 INTENSIVE CARE UNIT						
031 SUBPROVIDER						
033 NURSERY						
034 SKILLED NURSING FACILITY						
037 ANCILLARY SRVC COST CNTRS						
037 OPERATING ROOM	34,645			972,549		972,549
038 RECOVERY ROOM						
039 DELIVERY ROOM & LABOR ROO						
040 ANESTHESIOLOGY						
041 RADIOLOGY-DIAGNOSTIC	58,115			932,841		932,841
042 RADIOLOGY-THERAPEUTIC						
044 LABORATORY	35,587			861,850		861,850
046 WHOLE BLOOD & PACKED RED						
047 BLOOD STORING, PROCESSING						
048 INTRAVENOUS THERAPY						
049 RESPIRATORY THERAPY	4,297			197,704		197,704
050 PHYSICAL THERAPY	12,241			340,447		340,447
051 OCCUPATIONAL THERAPY						
052 SPEECH PATHOLOGY						
053 ELECTROCARDIOLOGY	8,289			244,135		244,135
054 ELECTROENCEPHALOGRAPHY						
055 MEDICAL SUPPLIES CHARGED	13,719			214,780		214,780
055 30 IMPL. DEV. CHARGED TO PAT	5,097			311,835		311,835
056 DRUGS CHARGED TO PATIENTS	13,682			435,027		435,027
057 RENAL DIALYSIS						
058 ASC (NON-DISTINCT PART)						
059 O/P PSYCH				39,036		39,036
059 01 SLEEP LAB	4,535			120,038		120,038
060 OUTPAT SERVICE COST CNTRS						
061 CLINIC						
061 EMERGENCY	19,153			1,158,330		1,158,330
062 OBSERVATION BEDS (NON-DIS						
062 OTHER REIMBURS COST CNTRS						
064 HOME PROGRAM DIALYSIS						
065 AMBULANCE SERVICES						
070 I&R SERVICES-NOT APPRVD P						
071 HOME HEALTH AGENCY						
093 SPEC PURPOSE COST CENTERS						
093 HOSPICE						
095 SUBTOTALS	225,169			6,930,563		6,930,563
096 NONREIMBURS COST CENTERS						
096 GIFT, FLOWER, COFFEE SHOP				6,121		6,121
097 RESEARCH						
098 PHYSICIANS' PRIVATE OFFIC				235,253		235,253
099 NONPAID WORKERS						
100 PUBLIC RELATIONS				231,193		231,193
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 TOTAL	225,169			7,403,130		7,403,130

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	DIR ASSIGNED NEW CAPITAL REL COSTS	NEW CAP REL COSTS-BLDG & OSTS-MVBLE E	NEW CAP REL COSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT
	0	3	4	4a	5	6	8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS						46,208	
008 ADMINISTRATIVE & GENERAL		46,208		46,208			23,000
009 OPERATION OF PLANT		17,871		17,871		5,129	854
010 LAUNDRY & LINEN SERVICE		8,029		8,029		70	124
011 HOUSEKEEPING		1,164		1,164		840	458
012 DIETARY		23,242		23,242		756	2,472
014 CAFETERIA						363	86
015 NURSING ADMINISTRATION		812		812		518	707
016 CENTRAL SERVICES & SUPPLY		6,643		6,643		1,166	433
017 PHARMACY						1,234	
018 MEDICAL RECORDS & LIBRARY		4,070		4,070			
020 SOCIAL SERVICE							
025 NONPHYSICIAN ANESTHETISTS							
026 INPAT ROUTINE SRVC CNTRS							
031 ADULTS & PEDIATRICS		37,650		37,650		4,371	4,005
033 INTENSIVE CARE UNIT							
034 SUBPROVIDER							
037 NURSERY							
038 SKILLED NURSING FACILITY							
039 ANCILLARY SRVC COST CNTRS							
041 OPERATING ROOM		34,388		34,388		4,601	3,658
042 RECOVERY ROOM							
044 DELIVERY ROOM & LABOR ROO							
046 ANESTHESIOLOGY							
047 RADIOLOGY-DIAGNOSTIC		18,660		18,660		4,784	1,985
048 RADIOLOGY-THERAPEUTIC							
049 LABORATORY		7,851		7,851		4,859	835
050 WHOLE BLOOD & PACKED RED							
051 BLOOD STORING, PROCESSING							
052 INTRAVENOUS THERAPY							
053 RESPIRATORY THERAPY						1,173	
054 PHYSICAL THERAPY		6,832		6,832		1,768	727
055 OCCUPATIONAL THERAPY							
056 SPEECH PATHOLOGY							
057 ELECTROCARDIOLOGY		10,294		10,294		1,055	1,095
058 ELECTROENCEPHALOGRAPHY							
059 MEDICAL SUPPLIES CHARGED						563	
060 30 IMPL. DEV. CHARGED TO PAT						1,899	
061 DRUGS CHARGED TO PATIENTS		393		393		1,418	42
062 RENAL DIALYSIS							
064 ASC (NON-DISTINCT PART)							
065 O/P PSYCH		3,080		3,080		160	328
066 01 SLEEP LAB						700	
067 OUTPAT SERVICE COST CNTRS							
068 CLINIC							
069 EMERGENCY		16,992		16,992		6,284	1,808
070 OBSERVATION BEDS (NON-DIS							
071 OTHER REIMBURS COST CNTRS							
072 HOME PROGRAM DIALYSIS							
073 AMBULANCE SERVICES							
074 I&R SERVICES-NOT APPRVD P							
075 HOME HEALTH AGENCY							
076 SPEC PURPOSE COST CENTERS							
077 HOSPICE							
078 SUBTOTALS		244,179		244,179		44,169	19,159
079 NONREIMBURS COST CENTERS							
080 GIFT, FLOWER, COFFEE SHOP		960		960		8	102
081 RESEARCH							
082 PHYSICIANS' PRIVATE OFFIC		31,956		31,956		671	3,400
083 NONPAID WORKERS							
084 PUBLIC RELATIONS		3,188		3,188		1,360	339
085 CROSS FOOT ADJUSTMENTS							
086 NEGATIVE COST CENTER							
087 TOTAL		280,283		280,283		46,208	23,000

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	CENTRAL SERVI CES & SUPPLY	PHARMACY
	9	10	11	12	14	15	16
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE	8,953						
011 HOUSEKEEPING	58	2,186					
012 DIETARY	469		26,641				
014 CAFETERIA		15		771			
015 NURSING ADMINISTRATION				13	1,274		
016 CENTRAL SERVICES & SUPPLY		29		20		7,917	
017 PHARMACY				15			1,181
018 MEDICAL RECORDS & LIBRARY		50		56			
020 SOCIAL SERVICE							
025 NONPHYSICIAN ANESTHETISTS							
026 INPAT ROUTINE SRVC CNTRS							
031 ADULTS & PEDIATRICS	2,560	514	26,641	134	262		
033 INTENSIVE CARE UNIT							
034 SUBPROVIDER							
037 NURSERY							
038 SKILLED NURSING FACILITY							
039 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM	1,189	645		78	220		
041 RECOVERY ROOM							
042 DELIVERY ROOM & LABOR ROO							
044 ANESTHESIOLOGY							
046 RADIOLOGY-DIAGNOSTIC	884	112		96	220		
047 RADIOLOGY-THERAPEUTIC							
049 LABORATORY		91		63	44		
050 WHOLE BLOOD & PACKED RED							
051 BLOOD STORING, PROCESSING							
052 INTRAVENOUS THERAPY							
053 RESPIRATORY THERAPY					110		
054 PHYSICAL THERAPY	723	68		44	88		
055 OCCUPATIONAL THERAPY							
056 SPEECH PATHOLOGY							
057 ELECTROCARDIOLOGY	561	97		92	88		
058 ELECTROENCEPHALOGRAPHY							
059 MEDICAL SUPPLIES CHARGED						7,740	
060 30 IMPL. DEV. CHARGED TO PAT						177	
061 DRUGS CHARGED TO PATIENTS		38			22		1,181
062 RENAL DIALYSIS							
064 ASC (NON-DISTINCT PART)				5			
065 O/P PSYCH		15					
066 01 SLEEP LAB		53					
067 OUTPAT SERVICE COST CNTRS							
068 CLINIC							
069 EMERGENCY	2,509	379		132	220		
070 OBSERVATION BEDS (NON-DIS							
071 OTHER REIMBURS COST CNTRS							
072 HOME PROGRAM DIALYSIS							
073 AMBULANCE SERVICES							
074 I&R SERVICES-NOT APPRVD P							
075 HOME HEALTH AGENCY							
076 SPEC PURPOSE COST CENTERS							
077 HOSPICE							
078 SUBTOTALS	8,953	2,106	26,641	748	1,274	7,917	1,181
079 NONREIMBURS COST CENTERS							
080 GIFT, FLOWER, COFFEE SHOP		18					
081 RESEARCH							
082 PHYSICIANS' PRIVATE OFFIC		62		15			
083 NONPAID WORKERS				8			
084 PUBLIC RELATIONS							
085 CROSS FOOT ADJUSTMENTS							
086 NEGATIVE COST CENTER							
087 TOTAL	8,953	2,186	26,641	771	1,274	7,917	1,181

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	17	18	20	25	26	27
003 GENERAL SERVICE COST CNTR						
004 NEW CAP REL COSTS-BLDG &						
005 NEW CAP REL COSTS-MVBLE E						
006 EMPLOYEE BENEFITS						
008 ADMINISTRATIVE & GENERAL						
009 OPERATION OF PLANT						
010 LAUNDRY & LINEN SERVICE						
011 HOUSEKEEPING						
012 DIETARY						
014 CAFETERIA						
015 NURSING ADMINISTRATION						
016 CENTRAL SERVICES & SUPPLY						
017 PHARMACY						
018 MEDICAL RECORDS & LIBRARY	5,843					
020 SOCIAL SERVICE						
025 NONPHYSICIAN ANESTHETISTS						
026 INPAT ROUTINE SRVC CNTRS						
031 ADULTS & PEDIATRICS	410			76,547		76,547
033 INTENSIVE CARE UNIT						
034 SUBPROVIDER						
037 NURSERY						
038 SKILLED NURSING FACILITY						
039 ANCILLARY SRVC COST CNTRS						
040 OPERATING ROOM	898			45,677		45,677
041 RECOVERY ROOM						
042 DELIVERY ROOM & LABOR ROO						
044 ANESTHESIOLOGY						
046 RADIOLOGY-DIAGNOSTIC	1,511			28,252		28,252
047 RADIOLOGY-THERAPEUTIC						
049 LABORATORY	923			14,666		14,666
050 WHOLE BLOOD & PACKED RED						
051 BLOOD STORING, PROCESSING						
052 INTRAVENOUS THERAPY						
053 RESPIRATORY THERAPY	111			1,394		1,394
055 PHYSICAL THERAPY	317			10,567		10,567
056 OCCUPATIONAL THERAPY						
057 SPEECH PATHOLOGY						
058 ELECTROCARDIOLOGY	215			13,497		13,497
059 ELECTROENCEPHALOGRAPHY						
060 MEDICAL SUPPLIES CHARGED	356			8,659		8,659
061 30 IMPL. DEV. CHARGED TO PAT	132			2,208		2,208
062 DRUGS CHARGED TO PATIENTS	355			3,449		3,449
064 RENAL DIALYSIS						
065 ASC (NON-DISTINCT PART)						
066 O/P PSYCH				3,588		3,588
067 01 SLEEP LAB	118			871		871
068 OUTPAT SERVICE COST CNTRS						
069 CLINIC						
070 EMERGENCY	497			28,821		28,821
071 OBSERVATION BEDS (NON-DIS						
072 OTHER REIMBURS COST CNTRS						
073 HOME PROGRAM DIALYSIS						
074 AMBULANCE SERVICES						
075 I&R SERVICES-NOT APPRVD P						
076 HOME HEALTH AGENCY						
077 SPEC PURPOSE COST CENTERS						
078 HOSPICE						
079 SUBTOTALS	5,843			238,196		238,196
080 NONREIMBURS COST CENTERS						
081 GIFT, FLOWER, COFFEE SHOP				1,088		1,088
082 RESEARCH						
083 PHYSICIANS' PRIVATE OFFIC				36,104		36,104
084 NONPAID WORKERS						
085 PUBLIC RELATIONS				4,895		4,895
086 CROSS FOOT ADJUSTMENTS						
087 NEGATIVE COST CENTER						
088 TOTAL	5,843			280,283		280,283

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP' REL C	EMPLOYEE BENE	S RECONCIL-) IATION	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
	OSTS-BLDG &	OSTS-MVBLE	E FITS		(ACCUM. COST	(SQUARE FEET)
	(SQUARE FEET	(DOLLAR)VALUE	(GROSS)ALARIES	6a.00	6	8
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	75,613					
005 NEW CAP REL COSTS-MVB						
006 EMPLOYEE BENEFITS			2,974,237			
008 ADMINISTRATIVE & GENE	12,466		424,895	-2,133,040	5,270,090	
009 OPERATION OF PLANT	4,821		73,138		584,925	58,326
010 LAUNDRY & LINEN SERVI	2,166				8,029	2,166
011 HOUSEKEEPING	314		57,857		95,784	314
012 DIETARY	6,270		16,717		52,206	6,270
014 CAFETERIA			63,408		86,181	
015 NURSING ADMINISTRATIO	219		30,877		41,434	219
016 CENTRAL SERVICES & SU	1,792		35,844		59,084	1,792
017 PHARMACY			76,445		132,955	
018 MEDICAL RECORDS & LIB	1,098		103,247		140,694	1,098
020 SOCIAL SERVICE						
025 NONPHYSICIAN ANESTHET						
026 INPAT ROUTINE SRVC CN	10,157		325,603		498,539	10,157
031 ADULTS & PEDIATRICS						
033 INTENSIVE CARE UNIT						
034 SUBPROVIDER						
037 NURSERY						
038 SKILLED NURSING FACIL						
039 ANCILLARY SRVC COST C						
040 OPERATING ROOM	9,277		251,797		524,791	9,277
041 RECOVERY ROOM						
042 DELIVERY ROOM & LABOR						
044 ANESTHESIOLOGY						
046 RADIOLOGY-DIAGNOSTIC	5,034		254,382		545,639	5,034
047 RADIOLOGY-THERAPEUTIC						
048 LABORATORY	2,118		169,114		554,134	2,118
049 WHOLE BLOOD & PACKED						
050 BLOOD STORING, PROCES						
051 INTRAVENOUS THERAPY						
052 RESPIRATORY THERAPY			94,463		133,789	
053 PHYSICAL THERAPY	1,843		144,299		201,654	1,843
054 OCCUPATIONAL THERAPY						
055 SPEECH PATHOLOGY						
056 ELECTROCARDIOLOGY	2,777		80,880		120,293	2,777
057 ELECTROENCEPHALOGRAPH					64,264	
058 MEDICAL SUPPLIES CHAR					216,552	
059 30 IMPL. DEV. CHARGED TO					161,683	
060 DRUGS CHARGED TO PATI	106					106
061 RENAL DIALYSIS						
062 ASC (NON-DISTINCT PAR						
064 O/P PSYCH	831		11,305		18,269	831
065 01 SLEEP LAB			56,449		79,825	
066 OUTPAT SERVICE COST C						
067 CLINIC						
068 EMERGENCY	4,584		653,896		716,819	4,584
069 OBSERVATION BEDS (NON						
070 OTHER REIMBURS COST C						
071 HOME PROGRAM DIALYSIS						
072 AMBULANCE SERVICES						
073 I&R SERVICES-NOT APPR						
074 HOME HEALTH AGENCY						
075 SPEC PURPOSE COST CEN						
076 HOSPICE						
077 SUBTOTALS	65,873		2,924,616	-2,133,040	5,037,543	48,586
078 NONREIMBURS COST CENT						
079 GIFT, FLOWER, COFFEE	259				960	259
080 RESEARCH						
081 PHYSICIANS' PRIVATE O	8,621		26,790		76,518	8,621
082 NONPAID WORKERS						
083 PUBLIC RELATIONS	860		22,831		155,069	860
084 CROSS FOOT ADJUSTMENT						
085 NEGATIVE COST CENTER						
086 COST TO BE ALLOCATED	280,283		977,762		2,133,040	821,670
087 (WRKSHT B, PART I)						
088 UNIT COST MULTIPLIER	3.706810		.328744		.404745	14.087542
089 (WRKSHT B, PT I)						
090 COST TO BE ALLOCATED						
091 (WRKSHT B, PART II)						
092 UNIT COST MULTIPLIER						
093 (WRKSHT B, PT II)						
094 COST TO BE ALLOCATED					46,208	23,000
095 (WRKSHT B, PART III)						
096 UNIT COST MULTIPLIER					.008768	.394335
097 (WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	SERVI PHARMACY	R
		(POUNDS OF LAUNDRY)	(HOURS OF SERVICE)	(MEALS SERVED)	S(MEALS SERVED)	S(DIRECT)SING HRS	NR(UNITS)	(COSTED)EQUIS.	
		9	10	11	12	14	15	16	
003	GENERAL SERVICE COST								
004	NEW CAP REL COSTS-BLD								
005	NEW CAP REL COSTS-MVB								
006	EMPLOYEE BENEFITS								
008	ADMINISTRATIVE & GENE OPERATION OF PLANT								
009	LAUNDRY & LINEN SERVI	7,726							
010	HOUSEKEEPING	50	744						
011	DIETARY	405		647					
012	CAFETERIA		5		86,249				
014	NURSING ADMINISTRATIO				1,510	58			
015	CENTRAL SERVICES & SU		10		2,269		10,045		
016	PHARMACY				1,721			100	
017	MEDICAL RECORDS & LIB		17		6,278				
018	SOCIAL SERVICE								
020	NONPHYSICIAN ANESTHET								
025	INPAT ROUTINE SRVC CN								
026	ADULTS & PEDIATRICS	2,209	175	647	14,910	12			
031	INTENSIVE CARE UNIT								
033	SUBPROVIDER								
034	NURSERY								
037	SKILLED NURSING FACIL								
038	ANCILLARY SRVC COST C								
039	OPERATING ROOM	1,026	220		8,737	10			
040	RECOVERY ROOM								
041	DELIVERY ROOM & LABOR								
042	ANESTHESIOLOGY								
044	RADIOLOGY-DIAGNOSTIC	763	38		10,711	10			
046	RADIOLOGY-THERAPEUTIC								
047	LABORATORY		31		7,084	2			
048	WHOLE BLOOD & PACKED								
049	BLOOD STORING, PROCES								
050	INTRAVENOUS THERAPY								
051	RESPIRATORY THERAPY					5			
052	PHYSICAL THERAPY	624	23		4,890	4			
053	OCCUPATIONAL THERAPY								
054	SPEECH PATHOLOGY								
055	ELECTROCARDIOLOGY	484	33		10,305	4			
056	ELECTROENCEPHALOGRAPH								
057	MEDICAL SUPPLIES CHAR						9,820		
058	30 IMPL. DEV. CHARGED TO						225		
059	DRUGS CHARGED TO PATI		13			1		100	
060	RENAL DIALYSIS								
061	ASC (NON-DISTINCT PAR								
062	O/P PSYCH		5		516				
064	01 SLEEP LAB		18						
065	OUTPAT SERVICE COST C								
066	CLINIC								
067	EMERGENCY	2,165	129		14,750	10			
068	OBSERVATION BEDS (NON								
069	OTHER REIMBURS COST C								
070	HOME PROGRAM DIALYSIS								
071	AMBULANCE SERVICES								
072	I&R SERVICES-NOT APPR								
073	HOME HEALTH AGENCY								
074	SPEC PURPOSE COST CEN								
075	HOSPICE								
076	SUBTOTALS	7,726	717	647	83,681	58	10,045	100	
077	NONREIMBURS COST CENT								
078	GIFT, FLOWER, COFFEE		6						
079	RESEARCH								
080	PHYSICIANS' PRIVATE O		21		1,687				
081	NONPAID WORKERS								
082	PUBLIC RELATIONS				881				
083	CROSS FOOT ADJUSTMENT								
084	NEGATIVE COST CENTER								
085	COST TO BE ALLOCATED	41,793	139,245	163,856	121,998	63,425	113,324	189,202	
086	(WRKSHT B, PART I)								
087	UNIT COST MULTIPLIER		187.157258		1.414486		11.281633		
088	(WRKSHT B, PT I)	5.409397		253.255023		1,093.534483		1,892.020000	
089	COST TO BE ALLOCATED								
090	(WRKSHT B, PART II)								
091	UNIT COST MULTIPLIER								
092	(WRKSHT B, PT II)								
093	COST TO BE ALLOCATED	8,953	2,186	26,641	771	1,274	7,917	1,181	
094	(WRKSHT B, PART III)								
095	UNIT COST MULTIPLIER		2.938172		.008939		.788153		
096	(WRKSHT B, PT III)	1.158814		41.176198		21.965517		11.810000	

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS
	(REVENUE	(TIME SPENT	(ASSIGNED TIME)
	17	18	20
003 GENERAL SERVICE COST			
004 NEW CAP REL COSTS-BLD			
005 NEW CAP REL COSTS-MVB			
006 EMPLOYEE BENEFITS			
008 ADMINISTRATIVE & GENE			
009 OPERATION OF PLANT			
010 LAUNDRY & LINEN SERVI			
011 HOUSEKEEPING			
012 DIETARY			
014 CAFETERIA			
015 NURSING ADMINISTRATIO			
016 CENTRAL SERVICES & SU			
017 PHARMACY			
018 MEDICAL RECORDS & LIB	17,070,609		
020 SOCIAL SERVICE			
025 NONPHYSICIAN ANESTHET			
026 INPAT ROUTINE SRVC CN			
031 ADULTS & PEDIATRICS	1,198,553		
033 INTENSIVE CARE UNIT			
034 SUBPROVIDER			
037 NURSERY			
038 SKILLED NURSING FACIL			
039 ANCILLARY SRVC COST C			
040 OPERATING ROOM	2,626,644		
041 RECOVERY ROOM			
042 DELIVERY ROOM & LABOR			
044 ANESTHESIOLOGY			
046 RADIOLOGY-DIAGNOSTIC	4,405,291		
047 RADIOLOGY-THERAPEUTIC			
048 LABORATORY	2,698,058		
049 WHOLE BLOOD & PACKED			
050 BLOOD STORING, PROCES			
051 INTRAVENOUS THERAPY			
052 RESPIRATORY THERAPY	325,753		
053 PHYSICAL THERAPY	928,028		
054 OCCUPATIONAL THERAPY			
055 SPEECH PATHOLOGY			
056 ELECTROCARDIOLOGY	628,461		
057 ELECTROENCEPHALOGRAPH			
058 MEDICAL SUPPLIES CHAR	1,040,082		
059 30 IMPL. DEV. CHARGED TO	386,453		
061 DRUGS CHARGED TO PATI	1,037,334		
062 RENAL DIALYSIS			
064 ASC (NON-DISTINCT PAR			
065 O/P PSYCH			
066 01 SLEEP LAB	343,833		
067 OUTPAT SERVICE COST C			
068 CLINIC			
069 EMERGENCY	1,452,119		
070 OBSERVATION BEDS (NON			
071 OTHER REIMBURS COST C			
073 HOME PROGRAM DIALYSIS			
074 AMBULANCE SERVICES			
075 I&R SERVICES-NOT APPR			
076 HOME HEALTH AGENCY			
077 SPEC PURPOSE COST CEN			
078 HOSPICE			
079 SUBTOTALS	17,070,609		
080 NONREIMBURS COST CENT			
081 GIFT, FLOWER, COFFEE			
082 RESEARCH			
083 PHYSICIANS' PRIVATE O			
084 NONPAID WORKERS			
085 PUBLIC RELATIONS			
086 CROSS FOOT ADJUSTMENT			
087 NEGATIVE COST CENTER			
088 COST TO BE ALLOCATED	225,169		
089 (PER WRKSHT B, PART			
090 UNIT COST MULTIPLIER			
091 (WRKSHT B, PT I)	.013190		
092 COST TO BE ALLOCATED			
093 (PER WRKSHT B, PART			
094 UNIT COST MULTIPLIER			
095 (WRKSHT B, PT II)			
096 COST TO BE ALLOCATED	5,843		
097 (PER WRKSHT B, PART			
098 UNIT COST MULTIPLIER			
099 (WRKSHT B, PT III)	.000342		

COMPUTATION OF RATIO OF COSTS TO CHARGES

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	1,101,991		1,101,991		
26	INTENSIVE CARE UNIT					
31	SUBPROVIDER					
33	NURSERY					
34	SKILLED NURSING FACILITY					
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	972,549		972,549		
38	RECOVERY ROOM					
39	DELIVERY ROOM & LABOR ROO					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	932,841		932,841		
42	RADIOLOGY-THERAPEUTIC					
44	LABORATORY	861,850		861,850		
46	WHOLE BLOOD & PACKED RED					
47	BLOOD STORING, PROCESSING					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	197,704		197,704		
50	PHYSICAL THERAPY	340,447		340,447		
51	OCCUPATIONAL THERAPY					
52	SPEECH PATHOLOGY					
53	ELECTROCARDIOLOGY	244,135		244,135		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	214,780		214,780		
55	30 IMPL. DEV. CHARGED TO PAT	311,835		311,835		
56	DRUGS CHARGED TO PATIENTS	435,027		435,027		
57	RENAL DIALYSIS					
58	ASC (NON-DISTINCT PART)					
59	O/P PSYCH	39,036		39,036		
59	01 SLEEP LAB	120,038		120,038		
60	OUTPAT SERVICE COST CNTRS					
61	CLINIC					
61	EMERGENCY	1,158,330		1,158,330		
62	OBSERVATION BEDS (NON-DIS	129,711		129,711		
62	OTHER REIMBURS COST CNTRS					
64	HOME PROGRAM DIALYSIS					
65	AMBULANCE SERVICES					
101	SUBTOTAL	7,060,274		7,060,274		
102	LESS OBSERVATION BEDS	129,711		129,711		
103	TOTAL	6,930,563		6,930,563		

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET C
 I I TO 6/30/2010 I PART I

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	1,081,835		1,081,835			
26	INTENSIVE CARE UNIT						
31	SUBPROVIDER						
33	NURSERY						
34	SKILLED NURSING FACILITY ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	301,753	2,324,891	2,626,644	.370263	.370263	
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	220,017	4,185,274	4,405,291	.211755	.211755	
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY	340,868	2,357,190	2,698,058	.319433	.319433	
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	83,019	242,734	325,753	.606914	.606914	
50	PHYSICAL THERAPY	189,499	738,530	928,029	.366850	.366850	
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY	54,213	574,249	628,462	.388464	.388464	
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	485,687	554,395	1,040,082	.206503	.206503	
55	30 IMPL. DEV. CHARGED TO PAT	331,458	54,995	386,453	.806916	.806916	
56	DRUGS CHARGED TO PATIENTS	442,719	594,614	1,037,333	.419371	.419371	
57	RENAL DIALYSIS						
58	ASC (NON-DISTINCT PART)						
59	O/P PSYCH						
59	01 SLEEP LAB		343,833	343,833	.349117	.349117	
60	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	4,078	1,448,041	1,452,119	.797683	.797683	
62	OBSERVATION BEDS (NON-DIS	4,547	112,171	116,718	1.111320	1.111320	
62	OTHER REIMBURS COST CNTRS						
64	HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES						
101	SUBTOTAL	3,539,693	13,530,917	17,070,610			
102	LESS OBSERVATION BEDS						
103	TOTAL	3,539,693	13,530,917	17,070,610			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
I 15-1314 I FROM 2/ 1/2010 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	1,101,991		1,101,991		
26	INTENSIVE CARE UNIT					
31	SUBPROVIDER					
33	NURSERY					
34	SKILLED NURSING FACILITY ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	972,549		972,549		
38	RECOVERY ROOM					
39	DELIVERY ROOM & LABOR ROO					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	932,841		932,841		
42	RADIOLOGY-THERAPEUTIC					
44	LABORATORY	861,850		861,850		
46	WHOLE BLOOD & PACKED RED					
47	BLOOD STORING, PROCESSING					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	197,704		197,704		
50	PHYSICAL THERAPY	340,447		340,447		
51	OCCUPATIONAL THERAPY					
52	SPEECH PATHOLOGY					
53	ELECTROCARDIOLOGY	244,135		244,135		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	214,780		214,780		
55	30 IMPL. DEV. CHARGED TO PAT	311,835		311,835		
56	DRUGS CHARGED TO PATIENTS	435,027		435,027		
57	RENAL DIALYSIS					
58	ASC (NON-DISTINCT PART)					
59	O/P PSYCH	39,036		39,036		
59	01 SLEEP LAB	120,038		120,038		
60	OUTPAT SERVICE COST CNTRS CLINIC					
61	EMERGENCY	1,158,330		1,158,330		
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	129,711		129,711		
64	HOME PROGRAM DIALYSIS					
65	AMBULANCE SERVICES					
101	SUBTOTAL	7,060,274		7,060,274		
102	LESS OBSERVATION BEDS	129,711		129,711		
103	TOTAL	6,930,563		6,930,563		

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
I 15-1314 I FROM 2/ 1/2010 I WORKSHEET C
I I TO 6/30/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	1,081,835		1,081,835			
26	INTENSIVE CARE UNIT						
31	SUBPROVIDER						
33	NURSERY						
34	SKILLED NURSING FACILITY						
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	301,753	2,324,891	2,626,644	.370263	.370263	
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	220,017	4,185,274	4,405,291	.211755	.211755	
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY	340,868	2,357,190	2,698,058	.319433	.319433	
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	83,019	242,734	325,753	.606914	.606914	
50	PHYSICAL THERAPY	189,499	738,530	928,029	.366850	.366850	
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY	54,213	574,249	628,462	.388464	.388464	
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	485,687	554,395	1,040,082	.206503	.206503	
55	30 IMPL. DEV. CHARGED TO PAT	331,458	54,995	386,453	.806916	.806916	
56	DRUGS CHARGED TO PATIENTS	442,719	594,614	1,037,333	.419371	.419371	
57	RENAL DIALYSIS						
58	ASC (NON-DISTINCT PART)						
59	O/P PSYCH						
59	01 SLEEP LAB		343,833	343,833	.349117	.349117	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	4,078	1,448,041	1,452,119	.797683	.797683	
62	OBSERVATION BEDS (NON-DIS	4,547	112,171	116,718	1.111320	1.111320	
	OTHER REIMBURS COST CNTRS						
64	HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES						
101	SUBTOTAL	3,539,693	13,530,917	17,070,610			
102	LESS OBSERVATION BEDS						
103	TOTAL	3,539,693	13,530,917	17,070,610			

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	972,549	45,677	926,872			972,549
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO						
41	ANESTHESIOLOGY						
42	RADIOLOGY-DIAGNOSTIC	932,841	28,252	904,589			932,841
44	RADIOLOGY-THERAPEUTIC						
46	LABORATORY	861,850	14,666	847,184			861,850
47	WHOLE BLOOD & PACKED RED						
48	BLOOD STORING, PROCESSING						
49	INTRAVENOUS THERAPY	197,704	1,394	196,310			197,704
50	RESPIRATORY THERAPY	340,447	10,567	329,880			340,447
51	PHYSICAL THERAPY						
52	OCCUPATIONAL THERAPY						
53	SPEECH PATHOLOGY						
54	ELECTROCARDIOLOGY	244,135	13,497	230,638			244,135
55	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	214,780	8,659	206,121			214,780
56	30 IMPL. DEV. CHARGED TO PAT	311,835	2,208	309,627			311,835
56	DRUGS CHARGED TO PATIENTS	435,027	3,449	431,578			435,027
57	RENAL DIALYSIS						
58	ASC (NON-DISTINCT PART)						
59	O/P PSYCH	39,036	3,588	35,448			39,036
59	01 SLEEP LAB	120,038	871	119,167			120,038
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
61	EMERGENCY	1,158,330	28,821	1,129,509			1,158,330
62	OBSERVATION BEDS (NON-DIS	129,711		129,711			129,711
62	OTHER REIMBURS COST CNTRS						
64	HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES						
101	SUBTOTAL	5,958,283	161,649	5,796,634			5,958,283
102	LESS OBSERVATION BEDS	129,711		129,711			129,711
103	TOTAL	5,828,572	161,649	5,666,923			5,828,572

WKST A	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
LINE NO.		7	.8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	2,626,644	.370263	.370263
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROO			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	4,405,291	.211755	.211755
42	RADIOLOGY-THERAPEUTIC			
44	LABORATORY	2,698,058	.319433	.319433
46	WHOLE BLOOD & PACKED RED			
47	BLOOD STORING, PROCESSING			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	325,753	.606914	.606914
50	PHYSICAL THERAPY	928,029	.366850	.366850
51	OCCUPATIONAL THERAPY			
52	SPEECH PATHOLOGY			
53	ELECTROCARDIOLOGY	628,462	.388464	.388464
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	1,040,082	.206503	.206503
55	30 IMPL. DEV. CHARGED TO PAT	386,453	.806916	.806916
56	DRUGS CHARGED TO PATIENTS	1,037,333	.419371	.419371
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART)			
59	O/P PSYCH			
59	01 SLEEP LAB	343,833	.349117	.349117
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	1,452,119	.797683	.797683
62	OBSERVATION BEDS (NON-DIS	116,718	1.111320	1.111320
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
101	SUBTOTAL	15,988,775		
102	LESS OBSERVATION BEDS	116,718		
103	TOTAL	15,872,057		

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	972,549	45,677	926,872			972,549
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO						
41	ANESTHESIOLOGY						
42	RADIOLOGY-DIAGNOSTIC	932,841	28,252	904,589			932,841
44	RADIOLOGY-THERAPEUTIC						
46	LABORATORY	861,850	14,666	847,184			861,850
47	WHOLE BLOOD & PACKED RED						
48	BLOOD STORING, PROCESSING						
49	INTRAVENOUS THERAPY	197,704	1,394	196,310			197,704
50	RESPIRATORY THERAPY	340,447	10,567	329,880			340,447
51	PHYSICAL THERAPY						
52	OCCUPATIONAL THERAPY						
53	SPEECH PATHOLOGY						
54	ELECTROCARDIOLOGY	244,135	13,497	230,638			244,135
55	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	214,780	8,659	206,121			214,780
56	30 IMPL. DEV. CHARGED TO PAT	311,835	2,208	309,627			311,835
56	DRUGS CHARGED TO PATIENTS	435,027	3,449	431,578			435,027
57	RENAL DIALYSIS						
58	ASC (NON-DISTINCT PART)						
59	O/P PSYCH	39,036	3,588	35,448			39,036
59	01 SLEEP LAB	120,038	871	119,167			120,038
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
61	EMERGENCY	1,158,330	28,821	1,129,509			1,158,330
62	OBSERVATION BEDS (NON-DIS	129,711		129,711			129,711
64	OTHER REIMBURS COST CNTRS						
65	HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES						
101	SUBTOTAL	5,958,283	161,649	5,796,634			5,958,283
102	LESS OBSERVATION BEDS	129,711		129,711			129,711
103	TOTAL	5,828,572	161,649	5,666,923			5,828,572

WKST A	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
LINE NO.		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	2,626,644	.370263	.370263
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROO			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	4,405,291	.211755	.211755
42	RADIOLOGY-THERAPEUTIC			
44	LABORATORY	2,698,058	.319433	.319433
46	WHOLE BLOOD & PACKED RED			
47	BLOOD STORING, PROCESSING			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	325,753	.606914	.606914
50	PHYSICAL THERAPY	928,029	.366850	.366850
51	OCCUPATIONAL THERAPY			
52	SPEECH PATHOLOGY			
53	ELECTROCARDIOLOGY	628,462	.388464	.388464
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	1,040,082	.206503	.206503
55	30 IMPL. DEV. CHARGED TO PAT	386,453	.806916	.806916
56	DRUGS CHARGED TO PATIENTS	1,037,333	.419371	.419371
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART)			
59	O/P PSYCH			
59	01 SLEEP LAB	343,833	.349117	.349117
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	1,452,119	.797683	.797683
62	OBSERVATION BEDS (NON-DIS	116,718	1.111320	1.111320
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
101	SUBTOTAL	15,988,775		
102	LESS OBSERVATION BEDS	116,718		
103	TOTAL	15,872,057		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2010 I PART V
 I 15-1314 I I

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	.370263		.370263		
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC	.211755		.211755		
42 RADIOLOGY-THERAPEUTIC					
44 LABORATORY	.319433		.319433		
46 WHOLE BLOOD & PACKED RED BLOOD CELLS					
47 BLOOD STORING, PROCESSING & TRANS.					
48 INTRAVENOUS THERAPY					
49 RESPIRATORY THERAPY	.606914		.606914		
50 PHYSICAL THERAPY	.366850		.366850		
51 OCCUPATIONAL THERAPY					
52 SPEECH PATHOLOGY					
53 ELECTROCARDIOLOGY	.388464		.388464		
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.206503		.206503		
55 30 IMPL. DEV. CHARGED TO PATIENT	.806916		.806916		
56 DRUGS CHARGED TO PATIENTS	.419371		.419371		
57 RENAL DIALYSIS					
58 ASC (NON-DISTINCT PART)					
59 O/P PSYCH					
59 01 SLEEP LAB	.349117		.349117		
60 OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY	.797683		.797683		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.111320		1.111320		
62 OTHER REIMBURS COST CNTRS					
64 HOME PROGRAM DIALYSIS					
65 AMBULANCE SERVICES					
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 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2010 I PART V
 I 15-1314 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		561,825			
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC		1,104,178			
42 RADIOLOGY-THERAPEUTIC					
44 LABORATORY		804,324			
46 WHOLE BLOOD & PACKED RED BLOOD CELLS					
47 BLOOD STORING, PROCESSING & TRANS.					
48 INTRAVENOUS THERAPY		15,882			
49 RESPIRATORY THERAPY		213,735			
50 PHYSICAL THERAPY					
51 OCCUPATIONAL THERAPY					
52 SPEECH PATHOLOGY					
53 ELECTROCARDIOLOGY		393,143			
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		191,632			
55 30 IMPL. DEV. CHARGED TO PATIENT		54,995			
56 DRUGS CHARGED TO PATIENTS		353,534			
57 RENAL DIALYSIS					
58 ASC (NON-DISTINCT PART)					
59 O/P PSYCH					
59 01 SLEEP LAB					
OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY		312,072			
62 OBSERVATION BEDS (NON-DISTINCT PART)		46,668			
OTHER REIMBURS COST CNTRS					
64 HOME PROGRAM DIALYSIS					
65 AMBULANCE SERVICES					
101 SUBTOTAL		4,051,988			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		4,051,988			

(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 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2010 I PART V
 I 15-1314 I I

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	HOSPITAL	
	All Other	Hospital I/P Part B Charges
	9	10
		11
(A) ANCILLARY SRVC COST CNTRS		
37 OPERATING ROOM	208,023	
38 RECOVERY ROOM		
39 DELIVERY ROOM & LABOR ROOM		
40 ANESTHESIOLOGY		
41 RADIOLOGY-DIAGNOSTIC	233,815	
42 RADIOLOGY-THERAPEUTIC		
44 LABORATORY	256,928	
46 WHOLE BLOOD & PACKED RED BLOOD CELLS		
47 BLOOD STORING, PROCESSING & TRANS.		
48 INTRAVENOUS THERAPY		
49 RESPIRATORY THERAPY	9,639	
50 PHYSICAL THERAPY	78,409	
51 OCCUPATIONAL THERAPY		
52 SPEECH PATHOLOGY		
53 ELECTROCARDIOLOGY	152,722	
54 ELECTROENCEPHALOGRAPHY		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	39,573	
55 30 IMPL. DEV. CHARGED TO PATIENT	44,376	
56 DRUGS CHARGED TO PATIENTS	148,262	
57 RENAL DIALYSIS		
58 ASC (NON-DISTINCT PART)		
59 O/P PSYCH		
59 01 SLEEP LAB		
60 OUTPAT SERVICE COST CNTRS		
60 CLINIC		
61 EMERGENCY	248,935	
62 OBSERVATION BEDS (NON-DISTINCT PART)	51,863	
62 OTHER REIMBURS COST CNTRS		
64 HOME PROGRAM DIALYSIS		
65 AMBULANCE SERVICES		
101 SUBTOTAL	1,472,545	
102 CRNA CHARGES		
103 LESS PBP CLINIC LAB SVCS-		
PROGRAM ONLY CHARGES		
104 NET CHARGES	1,472,545	

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

COMPUTATION OF INPATIENT OPERATING COST

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)	978
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	763
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	763
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	175
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	40
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	437
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)	175
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	146.75
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1,101,991
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	5,870
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	210,370
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	891,621

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,209,874
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,209,874
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.736954
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,585.68
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	891,621

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET D-1
 I COMPONENT NO: I TO 6/30/2010 I PART II
 I 15-1314 I I

COMPUTATION OF INPATIENT OPERATING COST

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 1,168.57
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 510,665
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 510,665

	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					
44 HOSPITAL UNITS					
45 INTENSIVE CARE UNIT					
46 CORONARY CARE UNIT					
47 BURN INTENSIVE CARE UNIT					
48 SURGICAL INTENSIVE CARE UNIT					
49 OTHER SPECIAL CARE					1
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					600,533
49 TOTAL PROGRAM INPATIENT COSTS					1,111,198

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) 204,500
 62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS 204,500
 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

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET D-1
 I COMPONENT NO: I TO 6/30/2010 I PART III
 I 15-1314 I I

COMPUTATION OF INPATIENT OPERATING COST

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
 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

1

PART IV - COMPUTATION OF OBSERVATION BED COST

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

111
 1,168.57
 129,711

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					

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 6/30/2010 I
 I 15-1314 I I

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

WKST A LINE NO.	TITLE XVIII, PART A COST CENTER DESCRIPTION	HOSPITAL	OTHER		
			RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			321,408	
26	INTENSIVE CARE UNIT				
31	SUBPROVIDER ANCILLARY SRVC COST CNTRS				
37	OPERATING ROOM		.370263	301,753	111,728
38	RECOVERY ROOM				
39	DELIVERY ROOM & LABOR ROOM				
40	ANESTHESIOLOGY				
41	RADIOLOGY-DIAGNOSTIC		.211755	116,101	24,585
42	RADIOLOGY-THERAPEUTIC				
44	LABORATORY		.319433	180,862	57,773
46	WHOLE BLOOD & PACKED RED BLOOD CELLS				
47	BLOOD STORING, PROCESSING & TRANS.				
48	INTRAVENOUS THERAPY				
49	RESPIRATORY THERAPY		.606914	70,126	42,560
50	PHYSICAL THERAPY		.366850	53,181	19,509
51	OCCUPATIONAL THERAPY				
52	SPEECH PATHOLOGY				
53	ELECTROCARDIOLOGY		.388464	49,316	19,157
54	ELECTROENCEPHALOGRAPHY				
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		.206503	237,513	49,047
55	30 IMPL. DEV. CHARGED TO PATIENT		.806916	211,078	170,322
56	DRUGS CHARGED TO PATIENTS		.419371	249,778	104,750
57	RENAL DIALYSIS				
58	ASC (NON-DISTINCT PART)				
59	O/P PSYCH				
59	01 SLEEP LAB		.349117		
60	OUTPAT SERVICE COST CNTRS CLINIC				
61	EMERGENCY		.797683	444	354
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS		1.111320	673	748
64	HOME PROGRAM DIALYSIS				
65	AMBULANCE SERVICES				
101	TOTAL			1,470,825	600,533
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES				
103	NET CHARGES			1,470,825	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 6/30/2010 I
 I 15-Z314 I I

TITLE XVIII, PART A

SWING BED SNF

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS			
26	ADULTS & PEDIATRICS			
31	INTENSIVE CARE UNIT			
37	SUBPROVIDER			
38	ANCILLARY SRVC COST CNTRS			
39	OPERATING ROOM	.370263		
40	RECOVERY ROOM			
41	DELIVERY ROOM & LABOR ROOM			
42	ANESTHESIOLOGY			
44	RADIOLOGY-DIAGNOSTIC	.211755	10,522	2,228
46	RADIOLOGY-THERAPEUTIC			
47	LABORATORY	.319433	23,210	7,414
48	WHOLE BLOOD & PACKED RED BLOOD CELLS			
49	BLOOD STORING, PROCESSING & TRANS.			
50	INTRAVENOUS THERAPY			
51	RESPIRATORY THERAPY	.606914	12,893	7,825
52	PHYSICAL THERAPY	.366850	92,463	33,920
53	OCCUPATIONAL THERAPY			
54	SPEECH PATHOLOGY			
55	ELECTROCARDIOLOGY	.388464	4,897	1,902
56	ELECTROENCEPHALOGRAPHY			
57	MEDICAL SUPPLIES CHARGED TO PATIENTS	.206503	29,123	6,014
58	30 IMPL. DEV. CHARGED TO PATIENT	.806916		
59	DRUGS CHARGED TO PATIENTS	.419371	42,046	17,633
60	RENAL DIALYSIS			
61	58 ASC (NON-DISTINCT PART)			
62	01 O/P PSYCH			
63	59 SLEEP LAB	.349117		
64	OUTPAT SERVICE COST CNTRS			
65	CLINIC			
101	61 EMERGENCY	.797683		
102	62 OBSERVATION BEDS (NON-DISTINCT PART)	1.111320		
103	OTHER REIMBURS COST CNTRS			
	64 HOME PROGRAM DIALYSIS			
	65 AMBULANCE SERVICES			
	TOTAL		215,154	76,936
	LESS PBP CLINIC LABORATORY SERVICES -			
	PROGRAM ONLY CHARGES			
	NET CHARGES		215,154	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	1,472,545
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)	1,472,545

COMPUTATION OF LESSER OF COST OR CHARGES

6	REASONABLE CHARGES	
7	ANCILLARY SERVICE CHARGES	
8	INTERNS AND RESIDENTS SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
11	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)	1,487,270
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	CAH DEDUCTIBLES	5,502
18.01	CAH ACTUAL BILLED COINSURANCE	651,093
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	830,675
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	830,675
24	PRIMARY PAYER PAYMENTS	433
25	SUBTOTAL	830,242

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	120,508
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	120,508
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	120,108
28	SUBTOTAL	950,750
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	950,750
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	599,179
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	351,571
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	

TO BE COMPLETED BY CONTRACTOR

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

IN LIEU OF FORM CMS-2552-96 (11/1998)
 I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET E-1
 I COMPONENT NO: I TO 6/30/2010 I
 I 15-1314 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		708,930		599,179
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER		.01		
ADJUSTMENTS TO PROVIDER		.02		
ADJUSTMENTS TO PROVIDER		.03		
ADJUSTMENTS TO PROVIDER		.04		
ADJUSTMENTS TO PROVIDER		.05		
ADJUSTMENTS TO PROGRAM		.50		
ADJUSTMENTS TO PROGRAM		.51		
ADJUSTMENTS TO PROGRAM		.52		
ADJUSTMENTS TO PROGRAM		.53		
ADJUSTMENTS TO PROGRAM		.54		
SUBTOTAL		.99		
4 TOTAL INTERIM PAYMENTS		708,930		599,179
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		
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER		.01		
SETTLEMENT TO PROGRAM		.02		
		317,975		351,571
7 TOTAL MEDICARE PROGRAM LIABILITY		1,026,905		950,750

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

IN LIEU OF FORM CMS-2552-96 (11/1998)
 I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET E-1
 I COMPONENT NO: I TO 6/30/2010 I
 I 15-Z314 I I

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		196,763		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01				
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL				NONE
4 TOTAL INTERIM PAYMENTS		196,763		
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL				NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER .01		85,974		
SETTLEMENT TO PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY		282,737		

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

IN LIEU OF FORM CMS-2552-96-E-2 (05/2004)
 I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I
 I COMPONENT NO: I TO 6/30/2010 I WORKSHEET E-2
 I 15-Z314 I I

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	206,545	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	77,705	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	175	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	284,250	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	284,250	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	284,250	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS) (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	1,513	
14	80% OF PART B COSTS		
15	SUBTOTAL	282,737	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	282,737	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	196,763	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	85,974	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

IN LIEU OF FORM CMS-2552-96-E-3 (04/2005)
 I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET E-3
 I COMPONENT NO: I TO 6/30/2010 I PART II
 I 15-1314 I I

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	1,111,198
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	1,111,198
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	1,122,310

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	
12	TOTAL REASONABLE CHARGES	
13	CUSTOMARY CHARGES	
14	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
15	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)	
16	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
17	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
18	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
19	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

20	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
21	COST OF COVERED SERVICES	1,122,310
22	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	110,766
23	EXCESS REASONABLE COST	
24	SUBTOTAL	1,011,544
25	COINSURANCE	
26	SUBTOTAL	1,011,544
27	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	15,361
28.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	15,361
28.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	15,361
29	SUBTOTAL	1,026,905
30	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
31	OTHER ADJUSTMENTS (SPECIFY)	
32	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
33	SUBTOTAL	1,026,905
34	SEQUESTRATION ADJUSTMENT	
35	INTERIM PAYMENTS	708,930
36.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
37	BALANCE DUE PROVIDER/PROGRAM	317,975
38	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	3,227,607			
2 TEMPORARY INVESTMENTS				
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	8,475,907			
5 OTHER RECEIVABLES	11,542			
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-5,957,929			
7 INVENTORY	418,572			
8 PREPAID EXPENSES	534,641			
9 OTHER CURRENT ASSETS	609,525			
10 DUE FROM OTHER FUNDS	632			
11 TOTAL CURRENT ASSETS	7,320,497			
FIXED ASSETS				
12 LAND				
12.01 LAND IMPROVEMENTS				
13.01 LESS ACCUMULATED DEPRECIATION				
14 BUILDINGS	70,893			
14.01 LESS ACCUMULATED DEPRECIATION				
15 LEASEHOLD IMPROVEMENTS				
15.01 LESS ACCUMULATED DEPRECIATION				
16 FIXED EQUIPMENT				
16.01 LESS ACCUMULATED DEPRECIATION				
17 AUTOMOBILES AND TRUCKS				
17.01 LESS ACCUMULATED DEPRECIATION				
18 MAJOR MOVABLE EQUIPMENT	146,830			
18.01 LESS ACCUMULATED DEPRECIATION	-5,193			
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE				
21 TOTAL FIXED ASSETS	212,530			
OTHER ASSETS				
22 INVESTMENTS				
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS	3,765,082			
26 TOTAL OTHER ASSETS	3,765,082			
27 TOTAL ASSETS	11,298,109			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE	662,070		
29	SALARIES, WAGES & FEES PAYABLE	496,455		
30	PAYROLL TAXES PAYABLE			
31	NOTES AND LOANS PAYABLE (SHORT TERM)			
32	DEFERRED INCOME	30,502		
33	ACCELERATED PAYMENTS			
34	DUE TO OTHER FUNDS	3,573,660		
35	OTHER CURRENT LIABILITIES	231,200		
36	TOTAL CURRENT LIABILITIES	4,993,887		
LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE			
38	NOTES PAYABLE			
39	UNSECURED LOANS			
40.01	LOANS PRIOR TO 7/1/66			
40.02	ON OR AFTER 7/1/66			
41	OTHER LONG TERM LIABILITIES			
42	TOTAL LONG-TERM LIABILITIES			
43	TOTAL LIABILITIES	4,993,887		
CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE	6,304,222		
45	SPECIFIC PURPOSE FUND			
46	DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED.			
47	DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT			
48	GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE			
49	PLANT FUND BALANCE-INVESTED IN PLANT			
50	PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION			
51	TOTAL FUND BALANCES	6,304,222		
52	TOTAL LIABILITIES AND FUND BALANCES	11,298,109		

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4
1	FUND BALANCE AT BEGINNING			
	OF PERIOD			
2	NET INCOME (LOSS)		152,073	
3	TOTAL		152,073	
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)			
4	TRANSFERS FROM AFFILIATES	6,127,444		
5	GRANT REVENUE	24,705		
6				
7				
8				
9				
10	TOTAL ADDITIONS		6,152,149	
11	SUBTOTAL		6,304,222	
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)			
12	DEDUCTIONS (DEBIT ADJUSTM			
13				
14				
15				
16				
17				
18	TOTAL DEDUCTIONS			
19	FUND BALANCE AT END OF		6,304,222	
	PERIOD PER BALANCE SHEET			

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 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	1,209,874		1,209,874
2 00 SUBPROVIDER			
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
6 00 SKILLED NURSING FACILITY			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	1,209,874		1,209,874
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	1,209,874		1,209,874
17 00 ANCILLARY SERVICES	2,420,345	14,072,486	16,492,831
18 00 OUTPATIENT SERVICES			
19 00 HOME HEALTH AGENCY			
20 00 AMBULANCE SERVICES			
23 00 HOSPICE			
24 00			
25 00 TOTAL PATIENT REVENUES	3,630,219	14,072,486	17,702,705

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		6,570,320	
ADD (SPECIFY)			
27 00 BAD DEBT	1,111,680		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		1,111,680	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		7,682,000	

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 11/22/2010
 I 15-1314 I FROM 2/ 1/2010 I WORKSHEET G-3
 I I TO 6/30/2010 I

DESCRIPTION		
1	TOTAL PATIENT REVENUES	17,702,705
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	9,981,077
3	NET PATIENT REVENUES	7,721,628
4	LESS: TOTAL OPERATING EXPENSES	7,682,000
5	NET INCOME FROM SERVICE TO PATIENTS	39,628
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	
7	INCOME FROM INVESTMENTS	10,806
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	27,964
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	3,198
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	71,472
23	GOVERNMENTAL APPROPRIATIONS	
24	MISCELLANEOUS REVENUE	810
25	TOTAL OTHER INCOME	114,250
26	TOTAL	153,878
	OTHER EXPENSES	
27	UNREALIZED GAIN/LOSS	1,805
28		
29		
30	TOTAL OTHER EXPENSES	1,805
31	NET INCOME (OR LOSS) FOR THE PERIOD	152,073