

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

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	15-1333	I	FROM 1/ 1/2010	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 12/31/2010	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
						--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/24/2011 TIME 11:30

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:
PUTNAM COUNTY HOSPITAL 15-1333
FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2010 AND ENDING 12/31/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
DATE: 5/24/2011 TIME 11:30

Oo:Pduxq:Du0U6nnWemYHgNdcM9PT0
Y2de50wqD8K7s2F5YysMTT9bpCXvry
urBn0K3rT80J19FY

PI ENCRYPTION INFORMATION
DATE: 5/24/2011 TIME 11:30

gefz443jPBkv3Imi7BpvIza4ppE1H0
Y5q3v0JrsOLRR9utJHEV2AL:nIoszb
Bnkz4xXLNp0XYZhe

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

	TITLE V		TITLE XVIII		TITLE XIX
	1	A 2	B 3	4	
1	HOSPITAL	0	-5,878	-124,973	251,730
3	SWING BED - SNF	0	-69,132	0	0
100	TOTAL	0	-75,010	-124,973	251,730

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.

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

FORM APPROVED
 OMB NO. 0938-0050

WORKSHEET S
 PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	I	15-1333	I	FROM 1/ 1/2010	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 12/31/2010	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/24/2011 TIME 11:29

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:
 PUTNAM COUNTY HOSPITAL 15-1333
 FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2010 AND ENDING 12/31/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX
	1	2	3	4	
1	HOSPITAL	0	-5,878	-124,973	251,730
3	SWING BED - SNF	0	-69,132	0	0
100	TOTAL	0	-75,010	-124,973	251,730

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS
 1 STREET: 1542 SOUTH BLOOMINGTON P.O. BOX:
 1.01 CITY: GREENCASTLE STATE: IN ZIP CODE: 46135- COUNTY: PUTNAM

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O OR N)		
0	1	2	2.01	3	V	XVIII	XIX
02.00	HOSPITAL	15-1333		12/31/2005	4	5	6
04.00	SWING BED - SNF	15-2333		12/31/2005	N	O	O
					N	O	N

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

18 TYPE OF CONTROL 1 2 9

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
 20 SUBPROVIDER

OTHER INFORMATION

- 21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.
- 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. N
- 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
- 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 Y 15
- 21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2
- 21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2
- 21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION (OR APPLICABLE EXTENSION) OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105, MIPPA §147, ACA §3121 OR MMEA §108? "Y" FOR YES, AND "N" FOR NO. N
- 21.07 DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER IN COL 1 "Y" FOR YES AND "N" FOR NO.(SEE INSTRUCTIONS) IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 or MMEA §108? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. (SEE INSTRUCTIONS) N N
- 21.08 WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEEDING COST REPORTING PERIOD? ENTER IN COLUMN 2, "Y" FOR YES OR "N" FOR NO.
- 22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N
- 23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N
- 23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. / / / /
- 23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY) / /
- 24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). / /

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.

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

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

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

25.07 HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THE COST REPORTING PERIOD? ENTER "Y" FOR YES OR "N" FOR NO IN COLUMN 1.

25.08 IF LINE 25.07 IS YES, ENTER IN COLUMN 1 THE WEIGHTED NUMBER OF NON-PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. 0.00

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

25.09 0000 0.00

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

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

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

27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 12/31/2005

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

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

	1	2	3	4
28.02	0	0.0000	0.0000	
28.02	0.00	0		

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MISCELLANEOUS COST REPORT INFORMATION

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

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

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

TITLE XIX INPATIENT SERVICES

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

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

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

- 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: 562,669
 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. Y
- 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.

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

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N

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

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

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

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

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

MULTICAMPUS

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

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

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00

SETTLEMENT DATA

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

MISCELLANEOUS DATA

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

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
I 15-1333 I FROM 1/1/2010 I WORKSHEET S-3
I I TO 12/31/2010 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	19	6,935	58,536.00		1,471		229
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF					334		
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	19	6,935	58,536.00		1,805		229
6 INTENSIVE CARE UNIT	6	2,190	15,816.00		406		
11 NURSERY							
12 TOTAL	25	9,125	74,352.00		2,211		229
13 RPCH VISITS							
25 TOTAL	25						
26 OBSERVATION BED DAYS							157
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	TITLE XIX ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	/ TRIPS TOTAL OBSERVATION BEDS ADMITTED 6.01	DISCHARGES TITLE XVIII 6.02	-- INTERNS & RES. FTES -- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			2,440				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			334				
4 ADULTS & PED-SB NF			160				
5 TOTAL ADULTS AND PEDS			2,934				
6 INTENSIVE CARE UNIT			659				
11 NURSERY			320				
12 TOTAL			3,913				
13 RPCH VISITS							
25 TOTAL							
26 OBSERVATION BED DAYS			766				
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	I & R FTES NET 9	--- FULL TIME EMPLOYEES ON PAYROLL 10	EQUIV --- NONPAID WORKERS 11	TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS					536	77	956
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		249.96			536	77	956
13 RPCH VISITS							
25 TOTAL		249.96					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:
I 15-1333
I

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

I PREPARED 5/24/2011
I WORKSHEET A
I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		2,127,376	2,127,376	149,836	2,277,212
5	0500 EMPLOYEE BENEFITS		3,766,245	3,766,245	49,035	3,815,280
6	0600 ADMINISTRATIVE & GENERAL	1,552,107	1,697,144	3,249,251	252,967	3,502,218
8	0800 OPERATION OF PLANT	184,973	948,592	1,133,565	35,434	1,168,999
9	0900 LAUNDRY & LINEN SERVICE	24,249	86,208	110,457		110,457
10	1000 HOUSEKEEPING	337,685	63,812	401,497		401,497
11	1100 DIETARY	314,133	267,852	581,985	-432,902	149,083
12	1200 CAFETERIA				432,902	432,902
14	1400 NURSING ADMINISTRATION	531,296	6,589	537,885		537,885
17	1700 MEDICAL RECORDS & LIBRARY	441,966	57,312	499,278		499,278
18	1800 SOCIAL SERVICE					
18.01	1950 UTILIZATION REVIEW	123,930	8,725	132,655		132,655
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	1,255,100	95,232	1,350,332	-31,814	1,318,518
26	2600 INTENSIVE CARE UNIT	746,331	35,800	782,131	-8,490	773,641
33	3300 NURSERY	114,871	1,124	115,995	-33	115,962
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	467,128	860,069	1,327,197	-593,389	733,808
38	3800 RECOVERY ROOM	119,824	10,764	130,588	-5,181	125,407
39	3900 DELIVERY ROOM & LABOR ROOM	80,725	-903	79,822	-508	79,314
40	4000 ANESTHESIOLOGY	644,484	74,514	718,998	-17,275	701,723
41	4100 RADIOLOGY-DIAGNOSTIC	535,515	267,828	803,343	-14,225	789,118
41.01	3450 NUCLEAR MEDICINE-DIAGNOSTIC		116,094	116,094	-24	116,070
41.02	3230 CAT SCAN	126,403	381,488	507,891	-52,443	455,448
44	4400 LABORATORY	611,942	1,320,732	1,932,674	-208,300	1,724,374
48	4800 INTRAVENOUS THERAPY					
49	4900 RESPIRATORY THERAPY	299,681	111,767	411,448	-4,997	406,451
50	5000 PHYSICAL THERAPY	95,224	335,330	430,554	-25,600	404,954
51	5100 OCCUPATIONAL THERAPY	1,518	73,612	75,130	-387	74,743
52	5200 SPEECH PATHOLOGY		8,582	8,582		8,582
53	5300 ELECTROCARDIOLOGY	42,689	87,341	130,030	-45	129,985
53.01	3650 CARDIAC REHAB	72,443	3,611	76,054	-594	75,460
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,334	-115,438	-110,104	860,693	750,589
55.30	5530 IMPL. DEV. CHARGED TO PATIENT				152,704	152,704
56	5600 DRUGS CHARGED TO PATIENTS	117,170	1,410,239	1,527,409	2,281,238	3,808,647
56.01	3480 ONCOLOGY	293,528	2,518,776	2,812,304	-2,287,569	524,735
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	43,988	2,808	46,796		46,796
61	6100 EMERGENCY	923,572	1,498,387	2,421,959	-43,761	2,378,198
62	6200 OBSERVATION BEDS (NON-DISTINCT PART) SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE					
89	8900 UTILIZATION REVIEW-SNF					
95	SUBTOTALS	10,107,809	18,127,612	28,235,421	487,272	28,722,693
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800 PHYSICIANS' PRIVATE OFFICES	2,689,590	858,378	3,547,968	-487,272	3,060,696
99	9900 NONPAID WORKERS					
99.01	9901 DME		1,098	1,098		1,098
99.02	9902 LACTATION CONSULTING					
99.03	9903 DIABETIC COUNSELING					
100	7950 VACANT SPACE					
101	TOTAL	12,797,399	18,987,088	31,784,487	-0-	31,784,487

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
I 15-1333 I FROM 1/ 1/2010 I WORKSHEET A
I I TO 12/31/2010 I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-143,891	2,133,321
5	0500 EMPLOYEE BENEFITS	-146	3,815,134
6	0600 ADMINISTRATIVE & GENERAL	-205,649	3,296,569
8	0800 OPERATION OF PLANT	-1,879	1,167,120
9	0900 LAUNDRY & LINEN SERVICE		110,457
10	1000 HOUSEKEEPING		401,497
11	1100 DIETARY	-6,766	142,317
12	1200 CAFETERIA	-69,232	363,670
14	1400 NURSING ADMINISTRATION		537,885
17	1700 MEDICAL RECORDS & LIBRARY	-7,116	492,162
18	1800 SOCIAL SERVICE		
18.01	1950 UTILIZATION REVIEW		132,655
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS		1,318,518
26	2600 INTENSIVE CARE UNIT		773,641
33	3300 NURSERY		115,962
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		733,808
38	3800 RECOVERY ROOM		125,407
39	3900 DELIVERY ROOM & LABOR ROOM		79,314
40	4000 ANESTHESIOLOGY	-509,274	192,449
41	4100 RADIOLOGY-DIAGNOSTIC	-240	788,878
41.01	3450 NUCLEAR MEDICINE-DIAGNOSTIC	-2,161	113,909
41.02	3230 CAT SCAN		455,448
44	4400 LABORATORY		1,724,374
48	4800 INTRAVENOUS THERAPY		
49	4900 RESPIRATORY THERAPY		406,451
50	5000 PHYSICAL THERAPY		404,954
51	5100 OCCUPATIONAL THERAPY	-7,432	67,311
52	5200 SPEECH PATHOLOGY		8,582
53	5300 ELECTROCARDIOLOGY		129,985
53.01	3650 CARDIAC REHAB	-4,700	70,760
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		750,589
55.30	5530 IMPL. DEV. CHARGED TO PATIENT		152,704
56	5600 DRUGS CHARGED TO PATIENTS	-22,537	3,786,110
56.01	3480 ONCOLOGY	-215,397	309,338
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC	-830	45,966
61	6100 EMERGENCY	-1,134,800	1,243,398
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
89	8900 UTILIZATION REVIEW-SNF		-0-
95	SUBTOTALS	-2,332,050	26,390,643
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800 PHYSICIANS' PRIVATE OFFICES		3,060,696
99	9900 NONPAID WORKERS		
99.01	9901 DME		1,098
99.02	9902 LACTATION CONSULTING		
99.03	9903 DIABETIC COUNSELING		
100	7950 VACANT SPACE		
101	TOTAL	-2,332,050	29,452,437

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I NOT A CMS WORKSHEET
 I I TO 12/31/2010 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
18.01	UTILIZATION REVIEW	1950	OTHER GENERAL SERVICE COST CENTERS
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
33	NURSERY	3300	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
38	RECOVERY ROOM	3800	
39	DELIVERY ROOM & LABOR ROOM	3900	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
41.01	NUCLEAR MEDICINE-DIAGNOSTIC	3450	NUCLEAR MEDICINE-DIAGNOSTIC
41.02	CAT SCAN	3230	CAT SCAN
44	LABORATORY	4400	
48	INTRAVENOUS THERAPY	4800	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
53.01	CARDIAC REHAB	3650	VASCULAR LAB
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	
56.01	ONCOLOGY	3480	ONCOLOGY
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
89	UTILIZATION REVIEW-SNF	8900	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
99	NONPAID WORKERS	9900	
99.01	DME	9901	NONPAID WORKERS
99.02	LACTATION CONSULTING	9902	NONPAID WORKERS
99.03	DIABETIC COUNSELING	9903	NONPAID WORKERS
100	VACANT SPACE	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO: 151333	PERIOD: FROM 1/ 1/2010 TO 12/31/2010	PREPARED 5/24/2011 WORKSHEET A-6
------------------------	--	-------------------------------------

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1)	COST CENTER	LINE NO	SALARY	OTHER
	1	2	3	4	5
1 CAFÉ RECLASS	A	CAFETERIA	12	233,664	199,238
2 EMPLOYEE PROMOTIONS	B	EMPLOYEE BENEFITS	5		6,456
3 INSURANCE RECLASS	C	NEW CAP REL COSTS-BLDG & FIXT	3		85,742
4		EMPLOYEE BENEFITS	5		42,579
5 DRUGS CHARGED A/C 660522	D	DRUGS CHARGED TO PATIENTS	56		2,281,844
6 PPO DEPRECIATION	E	NEW CAP REL COSTS-BLDG & FIXT	3		54,741
7 MED SUPPLIES	F	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		1,013,397
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26 PHYSICIAN PRACTICE A&G	G	ADMINISTRATIVE & GENERAL	6	386,322	
27 CLINIC RECLASS	J	OPERATION OF PLANT	8		35,434
28		NEW CAP REL COSTS-BLDG & FIXT	3		9,353
29		ADMINISTRATIVE & GENERAL	6		1,422
30 IMPLANTABLE DEVICES RECLASS	K	IMPL. DEV. CHARGED TO PATIENT	55.30		152,704
36 TOTAL RECLASSIFICATIONS				619,986	3,882,910

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151333	FROM 1/ 1/2010	5/24/2011
	TO 12/31/2010	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE			A-7 REF 10
			LINE NO	SALARY	OTHER	
	1	6	7	8	9	
1 CAFÉ RECLASS	A	DIETARY	11	233,664	199,238	
2 EMPLOYEE PROMOTIONS	B	ADMINISTRATIVE & GENERAL	6		6,456	
3 INSURANCE RECLASS	C	ADMINISTRATIVE & GENERAL	6		128,321	9
4						
5 DRUGS CHARGED A/C 660522	D	ONCOLOGY	56.01		2,281,844	
6 PPO DEPRECIATION	E	PHYSICIANS' PRIVATE OFFICES	98		54,741	9
7 MED SUPPLIES	F	ADULTS & PEDIATRICS	25		31,814	
8		INTENSIVE CARE UNIT	26		8,490	
9		NURSERY	33		33	
10		OPERATING ROOM	37		593,389	
11		RECOVERY ROOM	38		5,181	
12		DELIVERY ROOM & LABOR ROOM	39		508	
13		ANESTHESIOLOGY	40		17,275	
14		RADIOLOGY-DIAGNOSTIC	41		14,225	
15		NUCLEAR MEDICINE-DIAGNOSTIC	41.01		24	
16		CAT SCAN	41.02		52,443	
17		LABORATORY	44		208,300	
18		RESPIRATORY THERAPY	49		4,997	
19		PHYSICAL THERAPY	50		25,600	
20		OCCUPATIONAL THERAPY	51		387	
21		ELECTROCARDIOLOGY	53		45	
22		CARDIAC REHAB	53.01		594	
23		DRUGS CHARGED TO PATIENTS	56		606	
24		ONCOLOGY	56.01		5,725	
25		EMERGENCY	61		43,761	
26 PHYSICIAN PRACTICE A&G	G	PHYSICIANS' PRIVATE OFFICES	98	386,322		
27 CLINIC RECLASS	J	PHYSICIANS' PRIVATE OFFICES	98		46,209	
28						10
29						
30 IMPLANTABLE DEVICES RECLASS	K	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		152,704	
36 TOTAL RECLASSIFICATIONS				619,986	3,882,910	

(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: 151333 | PERIOD: FROM 1/1/2010 TO 12/31/2010 | PREPARED 5/24/2011 | WORKSHEET A-6 | NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : CAFÉ RECLASS

Table with columns: LINE, COST CENTER, INCREASE, LINE, AMOUNT. Row 1: 1.00 CAFETERIA 12 432,902. Total: 432,902.

Table with columns: COST CENTER, DECREASE, LINE, AMOUNT. Row 1: DIETARY 11 432,902. Total: 432,902.

RECLASS CODE: B
EXPLANATION : EMPLOYEE PROMOTIONS

Table with columns: LINE, COST CENTER, INCREASE, LINE, AMOUNT. Row 1: 1.00 EMPLOYEE BENEFITS 5 6,456. Total: 6,456.

Table with columns: COST CENTER, DECREASE, LINE, AMOUNT. Row 1: ADMINISTRATIVE & GENERAL 6 6,456. Total: 6,456.

RECLASS CODE: C
EXPLANATION : INSURANCE RECLASS

Table with columns: LINE, COST CENTER, INCREASE, LINE, AMOUNT. Rows: 1.00 NEW CAP REL COSTS-BLDG & FIXT 3 85,742; 2.00 EMPLOYEE BENEFITS 5 42,579. Total: 128,321.

Table with columns: COST CENTER, DECREASE, LINE, AMOUNT. Row 1: ADMINISTRATIVE & GENERAL 6 128,321. Total: 128,321.

RECLASS CODE: D
EXPLANATION : DRUGS CHARGED A/C 660522

Table with columns: LINE, COST CENTER, INCREASE, LINE, AMOUNT. Row 1: 1.00 DRUGS CHARGED TO PATIENTS 56 2,281,844. Total: 2,281,844.

Table with columns: COST CENTER, DECREASE, LINE, AMOUNT. Row 1: ONCOLOGY 56.01 2,281,844. Total: 2,281,844.

RECLASS CODE: E
EXPLANATION : PPO DEPRECIATION

Table with columns: LINE, COST CENTER, INCREASE, LINE, AMOUNT. Row 1: 1.00 NEW CAP REL COSTS-BLDG & FIXT 3 54,741. Total: 54,741.

Table with columns: COST CENTER, DECREASE, LINE, AMOUNT. Row 1: PHYSICIANS' PRIVATE OFFICES 98 54,741. Total: 54,741.

RECLASS CODE: F
EXPLANATION : MED SUPPLIES

Table with columns: LINE, COST CENTER, INCREASE, LINE, AMOUNT. Rows 1-19: 1.00 MEDICAL SUPPLIES CHARGED TO PA 55 1,013,397. Total: 1,013,397.

Table with columns: COST CENTER, DECREASE, LINE, AMOUNT. Rows 25-61: 25 ADULTS & PEDIATRICS 31,814; 26 INTENSIVE CARE UNIT 8,490; ... Total: 1,013,397.

RECLASS CODE: G
EXPLANATION : PHYSICIAN PRACTICE A&G

Table with columns: LINE, COST CENTER, INCREASE, LINE, AMOUNT. Row 1: 1.00 ADMINISTRATIVE & GENERAL 6 386,322. Total: 386,322.

Table with columns: COST CENTER, DECREASE, LINE, AMOUNT. Row 1: PHYSICIANS' PRIVATE OFFICES 98 386,322. Total: 386,322.

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151333	FROM 1/ 1/2010	5/24/2011
	TO 12/31/2010	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: J
 EXPLANATION : CLINIC RECLASS

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OPERATION OF PLANT	35,434	PHYSICIANS' PRIVATE OFFICES	98	46,209
2.00	NEW CAP REL COSTS-BLDG & FIXT	9,353			0
3.00	ADMINISTRATIVE & GENERAL	1,422			0
TOTAL RECLASSIFICATIONS FOR CODE J		46,209			46,209

RECLASS CODE: K
 EXPLANATION : IMPLANTABLE DEVICES RECLASS

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	IMPL. DEV. CHARGED TO PATIENT	152,704	MEDICAL SUPPLIES CHARGED TO PA	55	152,704
TOTAL RECLASSIFICATIONS FOR CODE K		152,704			152,704

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING	PURCHASES	ACQUISITIONS	TOTAL	DISPOSALS	ENDING	FULLY
		BALANCES		DONATION		AND		BALANCE
		1	2	3	4	5	6	7
1	LAND	455,443	1,399		1,399		456,842	
2	LAND IMPROVEMENTS	26,049,122	2,117,590		2,117,590		28,166,712	
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN	136,442	203,431		203,431		339,873	
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	13,284,062	441,617		441,617		13,725,679	
7	SUBTOTAL	39,925,069	2,764,037		2,764,037		42,689,106	
8	RECONCILING ITEMS		203,431		203,431		203,431	
9	TOTAL	39,925,069	2,560,606		2,560,606		42,485,675	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION	GROSS ASSETS	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL
		LEASES	GROSS ASSETS	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	
	1	2	3	4	5	6	7	8
* NEW CAP REL COSTS-BL								
5 TOTAL				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	
* NEW CAP REL COSTS-BL	1,791,963	9,353	332,005				2,133,321	
5 TOTAL	1,791,963	9,353	332,005				2,133,321	

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	
* NEW CAP REL COSTS-BL	1,651,480		475,896				2,127,376	
5 TOTAL	1,651,480		475,896				2,127,376	

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET A-8
 I I TO 12/31/2010 I

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON		WKST. A-7 REF. 5
			WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED	LINE NO	
	1	2	3 COST CENTER	4	5
1 INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3 INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			**COST CENTER DELETED**	4	
5 INVESTMENT INCOME-OTHER					
6 TRADE, QUANTITY AND TIME DISCOUNTS					
7 REFUNDS AND REBATES OF EXPENSES					
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9 TELEPHONE SERVICES					
10 TELEVISION AND RADIO SERVICE					
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-1,726,307			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS					
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS					
18 SALE OF MED AND SURG SUPPLIES					
19 SALE OF DRUGS TO OTHER THAN PATIENTS					
20 SALE OF MEDICAL RECORDS & ABSTRACTS					
21 NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22 VENDING MACHINES					
23 INCOME FROM IMPOSITION OF INTEREST					
24 INTRST EXP ON MEDICARE OVERPAYMENTS					
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28 UTILIZATION REVIEW--PHYSIAN COMP			UTILIZATION REVIEW-SNF	89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32 DEPRECIATION-NEW MOVABLE EQUIP			**COST CENTER DELETED**	4	
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34 PHYSICIANS' ASSISTANT					
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4	-7,432	OCCUPATIONAL THERAPY	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
37 DISCOUNTS	B	-4,067	ADMINISTRATIVE & GENERAL	6	
38 VENDOR REBATE/REFUND	B	-8,171	ADMINISTRATIVE & GENERAL	6	
39 PHARMACY REBATES	B	-21,824	DRUGS CHARGED TO PATIENTS	56	
40 BABY PHOTO SERVICE	B	-78	ADMINISTRATIVE & GENERAL	6	
41 SILVER RECOVERY	B	-2,161	NUCLEAR MEDICINE-DIAGNOST	41.01	
42 CARDIAC REHAB OTHER MISC INCOME	B	-3,380	CARDIAC REHAB	53.01	
43					
44 DIABETIC COUNSELING OTHER INCOME	B	-830	CLINIC	60	
45 MEDICAL RECORDS FEES	B	-7,116	MEDICAL RECORDS & LIBRARY	17	
46 VENDING MACHINES	B	-6,766	DIETARY	11	
47 CAFETERIA SALES	B	-69,232	CAFETERIA	12	
48 COMMUNITY HEALTH - OTHER INCOME	B	-410	ADMINISTRATIVE & GENERAL	6	
49 OTHER MISC INCOME	B	-2,051	ADMINISTRATIVE & GENERAL	6	
49.01 OTHER MISC INCOME	B	-240	RADIOLOGY-DIAGNOSTIC	41	
49.02 OTHER MISC INCOME	B	-713	DRUGS CHARGED TO PATIENTS	56	
49.03 NON-ALLOWABLE INTEREST EXPENSE	A	-103,022	NEW CAP REL COSTS-BLDG &	3	11
49.04 INVESTMENT INCOME	B	-40,869	NEW CAP REL COSTS-BLDG &	3	11
49.05 LOBBYING OFFSET	A	-867	ADMINISTRATIVE & GENERAL	6	
49.06 ADVERTISING OFFSET	A	-19,639	ADMINISTRATIVE & GENERAL	6	
49.07 COMMUNITY RELATIONS OFFSET	A	-107,671	ADMINISTRATIVE & GENERAL	6	
49.08 TELEPHONE WAGES	A	-605	ADMINISTRATIVE & GENERAL	6	
49.09 TELEPHONE BENEFITS	A	-146	EMPLOYEE BENEFITS	5	
49.10 TELEPHONE OTHER	A	-664	ADMINISTRATIVE & GENERAL	6	
49.11 TELEVISION OFFSET	A	-1,879	OPERATION OF PLANT	8	
49.12 PHYSICIAN RECRUITMENT	A	-61,426	ADMINISTRATIVE & GENERAL	6	
49.13 CRNA SALARY EXPENSE	A	-134,484	ANESTHESIOLOGY	40	
50 TOTAL (SUM OF LINES 1 THRU 49)		-2,332,050			

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET A-8-2
 I I TO 12/31/2010 I GROUP 1

LINE NO.	WKSHT A 1	COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN- ERATION 3	PROFES- SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	61	EMERGENCY	1,270,907	1,134,800	136,107				
2	40	DR SKRABAK	360,000	226,666	133,334				
3	40	DR PALANCA	149,999	148,124	1,875				
4	44	LAB	97,500		97,500				
5	56	1 ONCOLOGY	215,397	215,397					
6	53	1 CARDIAC REHAB	1,320	1,320					
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL	2,095,123	1,726,307	368,816				

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	365
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.45
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5

9	TOTAL HOURS WORKED		3077.00	1426.00	
10	AHSEA (SEE INSTRUCTIONS)		71.67	53.75	
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	35.84	35.84	26.88	
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	220,529
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	76,648
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	297,177
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	297,177

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	297,177

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	13,082
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	13,082
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	1,259
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	14,341
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	

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

I PROVIDER NO:
 I 15-1333
 I

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

I PREPARED 5/24/2011
 I WORKSHEET A-8-4
 I PARTS I - VII

PHYSICAL THERAPY

31 SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
 32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2,
 LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)
 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 14,341
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 297,177
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 14,341
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)
 60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)

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

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET A-8-4
 I I TO 12/31/2010 I PARTS I - VII

PHYSICAL THERAPY

61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)
 63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 311,518
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR 303,781
 RECORDS)
 65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF
 NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)

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

66 COST OF OUTSIDE SUPPLIER SERVICES - 303,781
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS 303,781
 LINE MUST AGREE WITH LINE 64)
 68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO 1.000000
 TOTAL COST- (LINE 66 DIVIDED BY LINE 67)
 68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO
 TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)
 68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO
 TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)
 69 EXCESS COST OVER LIMITATION-
 (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES
 AS INDICATED IN INSTRUCTIONS)
 69.01 EXCESS COST OVER LIMITATION-CORF I
 (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES
 AS INDICATED IN INSTRUCTIONS)
 69.31 EXCESS COST OVER LIMITATION- HHA I
 (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES
 AS INDICATED IN INSTRUCTIONS)
 70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE
 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE
 WITH LINE 65)

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

I PROVIDER NO: I 15-1333 I

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

I PREPARED 5/24/2011 I WORKSHEET A-8-4 I PARTS I - VII

RESPIRATORY THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	27
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.45
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5

9	TOTAL HOURS WORKED		420.00		
10	AHSEA (SEE INSTRUCTIONS)		56.33		
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	28.17	28.17		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	23,659
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	23,659
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	23,659

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	56.33
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	43,937
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	43,937

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	761
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	761
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	93
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	854
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	

RESPIRATORY THERAPY

31 SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
 32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2,
 LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)
 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 854
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 43,937
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 854
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)
 60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)

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

I PROVIDER NO:
I 15-1333
I

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

I PREPARED 5/24/2011
I WORKSHEET A-8-4
I PARTS I - VII

RESPIRATORY THERAPY

61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	44,791
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	10,290
65	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

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

66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	10,290
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	10,290
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

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

I PROVIDER NO:
I 15-1333
I

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

I PREPARED 5/24/2011
I WORKSHEET A-8-4
I PARTS I - VII

OCCUPATIONAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	162
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.45
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5

9	TOTAL HOURS WORKED		1004.00		
10	AHSEA (SEE INSTRUCTIONS)		52.56		
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	26.28	26.28		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	52,770
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	52,770
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	52,770

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	52,770

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	4,257
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	4,257
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	559
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	4,816
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	

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

I PROVIDER NO:
 I 15-1333
 I

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

I PREPARED 5/24/2011
 I WORKSHEET A-8-4
 I PARTS I - VII

OCCUPATIONAL THERAPY

31 SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
 32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2,
 LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)
 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 4,816
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 52,770
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 4,816
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)
 60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)

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

I PROVIDER NO:
I 15-1333
I

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

I PREPARED 5/24/2011
I WORKSHEET A-8-4
I PARTS I - VII

OCCUPATIONAL THERAPY

61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	57,586
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	65,018
65	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	7,432

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

66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	65,018
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	65,018
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	7,432
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	7,432

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

I PROVIDER NO:
I 15-1333
I

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

I PREPARED 5/24/2011
I WORKSHEET A-8-4
I PARTS I - VII

SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	52
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.45
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5

9	TOTAL HOURS WORKED		109.00		
10	AHSEA (SEE INSTRUCTIONS)		65.30		
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	32.65	32.65		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	7,118
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	7,118
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	7,118

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	65.30
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	50,934
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	50,934

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	1,698
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	1,698
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	179
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	1,877
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	

31 SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
 32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2,
 LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)
 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 1,877
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 50,934
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 1,877
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)
 60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)

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

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET A-8-4
 I I TO 12/31/2010 I PARTS I - VII

SPEECH PATHOLOGY

61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)
 63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 52,811
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 8,516
 65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)

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

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS) 8,516
 66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64) 8,516
 68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67) 1.000000
 68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)
 68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)
 69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
 69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
 69.31 EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
 70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I NOT A CMS WORKSHEET
 I I TO 12/31/2010 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS	SALARIES	NOT ENTERED
6	ADMINISTRATIVE & GENERAL	-6	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	3	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	9	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	3	SQUARE	FEET	ENTERED
11	DIETARY	11	MEALS	SERVED	ENTERED
12	CAFETERIA	12	MANHOURS		ENTERED
14	NURSING ADMINISTRATION	14	DIRECT	NRSING HRS	ENTERED
17	MEDICAL RECORDS & LIBRARY	17	TIME SPENT		ENTERED
18	SOCIAL SERVICE	18	PATIENT	DAYS	ENTERED
18.01	UTILIZATION REVIEW	18	PATIENT	DAYS	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG & FITS	EMPLOYEE BENE	SUBTOTAL	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE
	0	3	5	5a.00	6	8	9
003 GENERAL SERVICE COST CNTR							
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS	2,133,321	2,133,321					
006 ADMINISTRATIVE & GENERAL	3,296,569	285,703	577,881	4,160,153	4,160,153		
008 OPERATION OF PLANT	1,167,120	239,730	55,144	1,461,994	240,473	1,702,467	
009 LAUNDRY & LINEN SERVICE	110,457	14,243	7,229	131,929	21,700	15,081	168,710
010 HOUSEKEEPING	401,497	11,841	100,670	514,008	84,546	12,538	10,263
011 DIETARY	142,317	62,219	23,989	228,525	37,588	65,878	9,881
012 CAFETERIA	363,670	33,796	69,659	467,125	76,834	35,784	
014 NURSING ADMINISTRATION	537,885	14,011	158,389	710,285	116,830	14,835	
017 MEDICAL RECORDS & LIBRARY	492,162	88,071	131,758	711,991	117,110	93,252	
018 SOCIAL SERVICE		4,846		4,846	797	5,131	
018 01 UTILIZATION REVIEW	132,655	3,793	36,946	173,394	28,520	4,016	
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	1,318,518	202,922	374,168	1,895,608	311,795	214,858	47,589
026 INTENSIVE CARE UNIT	773,641	59,859	222,495	1,055,995	173,693	63,380	20,364
033 NURSERY	115,962	9,987	34,245	160,194	26,349	10,574	
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM	733,808	196,664	139,259	1,069,731	175,953	208,232	27,403
038 RECOVERY ROOM	125,407	48,355	35,722	209,484	34,457	51,199	
039 DELIVERY ROOM & LABOR ROO	79,314	35,397	24,066	138,777	22,826	37,479	
040 ANESTHESIOLOGY	192,449		192,132	384,581	63,257		
041 RADIOLOGY-DIAGNOSTIC	788,878	66,138	159,647	1,014,663	166,895	70,028	4,130
041 01 NUCLEAR MEDICINE-DIAGNOST	113,909	2,950		116,859	19,221	3,123	
041 02 CAT SCAN	455,448	27,812	37,683	520,943	85,686	29,448	
044 LABORATORY	1,724,374	52,084	182,431	1,958,889	322,204	55,148	
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	406,451	9,545	89,340	505,336	83,119	10,106	
050 PHYSICAL THERAPY	404,954	67,739	28,388	501,081	82,419	71,723	960
051 OCCUPATIONAL THERAPY	67,311		453	67,764	11,146		
052 SPEECH PATHOLOGY	8,582			8,582	1,412		
053 ELECTROCARDIOLOGY	129,985	2,107	12,726	144,818	23,820	2,231	
053 01 CARDIAC REHAB	70,760	15,233	21,597	107,590	17,697	16,129	
055 MEDICAL SUPPLIES CHARGED	750,589		1,590	752,179	123,721		
055 30 IMPL. DEV. CHARGED TO PAT	152,704			152,704	25,117		
056 DRUGS CHARGED TO PATIENTS	3,786,110	16,350	34,930	3,837,390	631,185	17,312	
056 01 ONCOLOGY	309,338	102,714	87,506	499,558	82,169	108,756	1,284
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC	45,966	3,413	13,114	62,493	10,279	3,614	4,853
061 EMERGENCY	1,243,398	126,502	275,333	1,645,233	270,613	133,943	36,781
062 OBSERVATION BEDS (NON-DIS SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	26,390,643	1,804,024	3,128,490	25,374,702	3,489,431	1,353,798	163,508
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP		10,050		10,050	1,653	10,641	
098 PHYSICIANS' PRIVATE OFFIC	3,060,696	262,570	686,644	4,009,910	659,566	278,017	5,202
099 NONPAID WORKERS							
099 01 DME	1,098			1,098	181		
099 02 LACTATION CONSULTING							
099 03 DIABETIC COUNSELING							
100 VACANT SPACE		56,677		56,677	9,322	60,011	
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	29,452,437	2,133,321	3,815,134	29,452,437	4,160,153	1,702,467	168,710

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN	MEDICAL RECOR	SOCIAL SERVIC	UTILIZATION R
	10	11	12	14	17	18	18.01
003 GENERAL SERVICE COST CNTR							
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL OPERATION OF PLANT							
008 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING	621,355						
011 DIETARY	24,440	366,312					
012 CAFETERIA	13,275		593,018				
014 NURSING ADMINISTRATION	5,504		21,219	868,673			
017 MEDICAL RECORDS & LIBRARY	34,596		47,601		1,004,550		
018 SOCIAL SERVICE	1,904					12,678	
018 01 UTILIZATION REVIEW	1,490						207,420
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	79,711	299,107	90,141	282,365	256,393	10,352	169,366
026 INTENSIVE CARE UNIT	23,513	67,205	50,304	157,576	41,551	2,326	38,054
033 NURSERY	3,923		8,414	26,358	31,815		
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	77,252		43,068	106,706	207,391		
038 RECOVERY ROOM	18,994		5,630	17,636			
039 DELIVERY ROOM & LABOR ROO	13,904		3,638	11,396			
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	25,980		42,743		134,181		
041 01 NUCLEAR MEDICINE-DIAGNOST	1,159						
041 02 CAT SCAN	10,925		10,874		18,386		
044 LABORATORY	20,459		55,304		25,544		
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	3,749		21,280				
050 PHYSICAL THERAPY	26,609				47,782		
051 OCCUPATIONAL THERAPY					3,060		
052 SPEECH PATHOLOGY					775		
053 ELECTROCARDIOLOGY	828		3,597		1,024		
053 01 CARDIAC REHAB	5,984		4,431	13,879			
055 MEDICAL SUPPLIES CHARGED			10,264				
055 30 IMPL. DEV. CHARGED TO PAT							
056 DRUGS CHARGED TO PATIENTS	6,423		9,065				
056 01 ONCOLOGY	40,348		22,012	68,951	45,729		
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC	1,341		2,358	7,385			
061 EMERGENCY	49,692		56,320	176,421	184,461		
062 OBSERVATION BEDS (NON-DIS SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	492,003	366,312	508,263	868,673	998,092	12,678	207,420
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP	3,948						
098 PHYSICIANS' PRIVATE OFFIC	103,140		84,755		6,458		
099 NONPAID WORKERS							
099 01 DME							
099 02 LACTATION CONSULTING							
099 03 DIABETIC COUNSELING							
100 VACANT SPACE	22,264						
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	621,355	366,312	593,018	868,673	1,004,550	12,678	207,420

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	25	26	27
003 GENERAL SERVICE COST CNTR			
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS			
006 ADMINISTRATIVE & GENERAL OPERATION OF PLANT			
009 LAUNDRY & LINEN SERVICE			
010 HOUSEKEEPING			
011 DIETARY			
012 CAFETERIA			
014 NURSING ADMINISTRATION			
017 MEDICAL RECORDS & LIBRARY			
018 SOCIAL SERVICE			
018 01 UTILIZATION REVIEW			
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	3,657,285		3,657,285
026 INTENSIVE CARE UNIT	1,693,961		1,693,961
033 NURSERY	267,627		267,627
037 ANCILLARY SRVC COST CNTRS OPERATING ROOM	1,915,736		1,915,736
038 RECOVERY ROOM	337,400		337,400
039 DELIVERY ROOM & LABOR ROO	228,020		228,020
040 ANESTHESIOLOGY	447,838		447,838
041 RADIOLOGY-DIAGNOSTIC	1,458,620		1,458,620
041 01 NUCLEAR MEDICINE-DIAGNOST	140,362		140,362
041 02 CAT SCAN	676,262		676,262
044 LABORATORY	2,437,548		2,437,548
048 INTRAVENOUS THERAPY			
049 RESPIRATORY THERAPY	623,590		623,590
050 PHYSICAL THERAPY	730,574		730,574
051 OCCUPATIONAL THERAPY	81,970		81,970
052 SPEECH PATHOLOGY	10,769		10,769
053 ELECTROCARDIOLOGY	176,318		176,318
053 01 CARDIAC REHAB	165,710		165,710
055 MEDICAL SUPPLIES CHARGED	886,164		886,164
055 30 IMPL. DEV. CHARGED TO PAT	177,821		177,821
056 DRUGS CHARGED TO PATIENTS	4,501,375		4,501,375
056 01 ONCOLOGY	868,807		868,807
060 OUTPAT SERVICE COST CNTRS CLINIC	92,323		92,323
061 EMERGENCY	2,553,464		2,553,464
062 OBSERVATION BEDS (NON-DIS SPEC PURPOSE COST CENTERS			
095 SUBTOTALS	24,129,544		24,129,544
096 NONREIMBURS COST CENTERS GIFT, FLOWER, COFFEE SHOP	26,292		26,292
098 PHYSICIANS' PRIVATE OFFIC	5,147,048		5,147,048
099 NONPAID WORKERS			
099 01 DME	1,279		1,279
099 02 LACTATION CONSULTING			
099 03 DIABETIC COUNSELING			
100 VACANT SPACE	148,274		148,274
101 CROSS FOOT ADJUSTMENT			
102 NEGATIVE COST CENTER			
103 TOTAL	29,452,437		29,452,437

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS 0	NEW CAP REL C OSTS-BLDG & 3	SUBTOTAL 4a	EMPLOYEE BENE FITS 5	ADMINISTRATIV E & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LIN EN SERVICE 9
003 GENERAL SERVICE COST CNTR							
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL		285,703	285,703		285,703		
008 OPERATION OF PLANT		239,730	239,730		16,515	256,245	
009 LAUNDRY & LINEN SERVICE		14,243	14,243		1,490	2,270	18,003
010 HOUSEKEEPING		11,841	11,841		5,806	1,887	1,095
011 DIETARY		62,219	62,219		2,581	9,916	1,054
012 CAFETERIA		33,796	33,796		5,277	5,386	
014 NURSING ADMINISTRATION		14,011	14,011		8,023	2,233	
017 MEDICAL RECORDS & LIBRARY		88,071	88,071		8,043	14,036	
018 SOCIAL SERVICE		4,846	4,846		55	772	
018 01 UTILIZATION REVIEW		3,793	3,793		1,959	604	
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		202,922	202,922		21,413	32,339	5,079
026 INTENSIVE CARE UNIT		59,859	59,859		11,929	9,540	2,173
033 NURSERY		9,987	9,987		1,810	1,592	
037 ANCILLARY SRVC COST CNTRS OPERATING ROOM		196,664	196,664		12,084	31,342	2,924
038 RECOVERY ROOM		48,355	48,355		2,366	7,706	
039 DELIVERY ROOM & LABOR ROO		35,397	35,397		1,568	5,641	
040 ANESTHESIOLOGY					4,344		
041 RADIOLOGY-DIAGNOSTIC		66,138	66,138		11,462	10,540	441
041 01 NUCLEAR MEDICINE-DIAGNOST		2,950	2,950		1,320	470	
041 02 CAT SCAN		27,812	27,812		5,885	4,432	
044 LABORATORY		52,084	52,084		22,128	8,301	
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY		9,545	9,545		5,708	1,521	
050 PHYSICAL THERAPY		67,739	67,739		5,660	10,795	102
051 OCCUPATIONAL THERAPY					765		
052 SPEECH PATHOLOGY					97		
053 ELECTROCARDIOLOGY		2,107	2,107		1,636	336	
053 01 CARDIAC REHAB		15,233	15,233		1,215	2,428	
055 MEDICAL SUPPLIES CHARGED					8,497		
055 30 IMPL. DEV. CHARGED TO PAT					1,725		
056 DRUGS CHARGED TO PATIENTS		16,350	16,350		43,347	2,606	
056 01 ONCOLOGY		102,714	102,714		5,643	16,369	137
060 OUTPAT SERVICE COST CNTRS CLINIC		3,413	3,413		706	544	518
061 EMERGENCY		126,502	126,502		18,585	20,160	3,925
062 OBSERVATION BEDS (NON-DIS SPEC PURPOSE COST CENTERS							
095 SUBTOTALS		1,804,024	1,804,024		239,642	203,766	17,448
096 NONREIMBURS COST CENTERS GIFT, FLOWER, COFFEE SHOP		10,050	10,050		114	1,602	
098 PHYSICIANS' PRIVATE OFFIC		262,570	262,570		45,295	41,844	555
099 NONPAID WORKERS							
099 01 DME					12		
099 02 LACTATION CONSULTING							
099 03 DIABETIC COUNSELING							
100 VACANT SPACE		56,677	56,677		640	9,033	
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		2,133,321	2,133,321		285,703	256,245	18,003

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART III

COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW
	10	11	12	14	17	18	18.01
003 GENERAL SERVICE COST CNTR							
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL OPERATION OF PLANT							
008 LAUNDRY & LINEN SERVICE							
009 HOUSEKEEPING	20,629						
010 DIETARY	811	76,581					
011 CAFETERIA	441		44,900				
012 NURSING ADMINISTRATION	183		1,607	26,057			
014 MEDICAL RECORDS & LIBRARY	1,149		3,604		114,903		
017 SOCIAL SERVICE	63					5,736	
018 01 UTILIZATION REVIEW	49						6,405
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	2,646	62,531	6,827	8,469	29,326	4,684	5,230
033 INTENSIVE CARE UNIT	781	14,050	3,809	4,727	4,753	1,052	1,175
037 NURSERY	130		637	791	3,639		
038 ANCILLARY SRVC COST CNTRS							
039 OPERATING ROOM	2,565		3,261	3,201	23,722		
040 RECOVERY ROOM	631		426	529			
041 DELIVERY ROOM & LABOR ROO	462		275	342			
041 ANESTHESIOLOGY							
041 01 RADIOLOGY-DIAGNOSTIC	863		3,236		15,348		
041 02 NUCLEAR MEDICINE-DIAGNOST	38						
044 02 CAT SCAN	363		823		2,103		
048 LABORATORY	679		4,187		2,922		
049 INTRAVENOUS THERAPY							
050 RESPIRATORY THERAPY	124		1,611				
051 PHYSICAL THERAPY	883				5,465		
052 OCCUPATIONAL THERAPY					350		
053 SPEECH PATHOLOGY					89		
053 01 ELECTROCARDIOLOGY	27		272		117		
055 30 CARDIAC REHAB	199		335	416			
055 01 MEDICAL SUPPLIES CHARGED			777				
056 30 IMPL. DEV. CHARGED TO PAT							
056 01 DRUGS CHARGED TO PATIENTS	213		686				
060 ONCOLOGY	1,340		1,667	2,068	5,231		
061 OUTPAT SERVICE COST CNTRS							
061 CLINIC	45		179	222			
062 EMERGENCY	1,650		4,264	5,292	21,099		
095 OBSERVATION BEDS (NON-DIS SPEC PURPOSE COST CENTERS							
096 SUBTOTALS	16,335	76,581	38,483	26,057	114,164	5,736	6,405
096 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP	131						
099 PHYSICIANS' PRIVATE OFFIC	3,424		6,417		739		
099 01 NONPAID WORKERS							
099 02 DME							
099 03 LACTATION CONSULTING							
100 03 DIABETIC COUNSELING							
101 VACANT SPACE	739						
102 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	20,629	76,581	44,900	26,057	114,903	5,736	6,405

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART III

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	25	26	27
003 GENERAL SERVICE COST CNTR			
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS			
006 ADMINISTRATIVE & GENERAL OPERATION OF PLANT			
008 LAUNDRY & LINEN SERVICE			
010 HOUSEKEEPING			
011 DIETARY			
012 CAFETERIA			
014 NURSING ADMINISTRATION			
017 MEDICAL RECORDS & LIBRARY			
018 SOCIAL SERVICE			
018 01 UTILIZATION REVIEW			
025 INPAT ROUTINE SRVC CNTRS			
025 ADULTS & PEDIATRICS	381,466		381,466
026 INTENSIVE CARE UNIT	113,848		113,848
033 NURSERY	18,586		18,586
037 ANCILLARY SRVC COST CNTRS			
037 OPERATING ROOM	275,763		275,763
038 RECOVERY ROOM	60,013		60,013
039 DELIVERY ROOM & LABOR ROO	43,685		43,685
040 ANESTHESIOLOGY	4,344		4,344
041 RADIOLOGY-DIAGNOSTIC	108,028		108,028
041 01 NUCLEAR MEDICINE-DIAGNOST	4,778		4,778
041 02 CAT SCAN	41,418		41,418
044 LABORATORY	90,301		90,301
048 INTRAVENOUS THERAPY			
049 RESPIRATORY THERAPY	18,509		18,509
050 PHYSICAL THERAPY	90,644		90,644
051 OCCUPATIONAL THERAPY	1,115		1,115
052 SPEECH PATHOLOGY	186		186
053 ELECTROCARDIOLOGY	4,495		4,495
053 01 CARDIAC REHAB	19,826		19,826
055 MEDICAL SUPPLIES CHARGED	9,274		9,274
055 30 IMPL. DEV. CHARGED TO PAT	1,725		1,725
056 DRUGS CHARGED TO PATIENTS	63,202		63,202
056 01 ONCOLOGY	135,169		135,169
060 OUTPAT SERVICE COST CNTRS			
060 CLINIC	5,627		5,627
061 EMERGENCY	201,477		201,477
062 OBSERVATION BEDS (NON-DIS SPEC PURPOSE COST CENTERS			
095 SUBTOTALS	1,693,479		1,693,479
096 NONREIMBURS COST CENTERS			
096 GIFT, FLOWER, COFFEE SHOP	11,897		11,897
098 PHYSICIANS' PRIVATE OFFIC	360,844		360,844
099 NONPAID WORKERS			
099 01 DME	12		12
099 02 LACTATION CONSULTING			
099 03 DIABETIC COUNSELING			
100 VACANT SPACE	67,089		67,089
101 CROSS FOOT ADJUSTMENTS			
102 NEGATIVE COST CENTER			
103 TOTAL	2,133,321		2,133,321

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	NEW CAP REL C	EMPLOYEE BENE	ADMINISTRATIVE OPERATION OF LAUNDRY & LIN			
	OSTS-BLDG & FITS	FITS	E & GENERAL	PLANT	EN SERVICE	
	(SQUARE FEET)	(GROSS SALARIES)	RECONCILIATION	(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF LAUNDRY)
	3	5	6a.00	6	8	9
003 GENERAL SERVICE COST						
005 NEW CAP REL COSTS-BLD	101,251					
006 EMPLOYEE BENEFITS		12,797,399				
008 ADMINISTRATIVE & GENE	13,560	1,938,429	-4,160,153	25,292,284		
009 OPERATION OF PLANT	11,378	184,973		1,461,994	76,313	
010 LAUNDRY & LINEN SERVI	676	24,249		131,929	676	40,603
011 HOUSEKEEPING	562	337,685		514,008	562	2,470
012 DIETARY	2,953	80,469		228,525	2,953	2,378
014 CAFETERIA	1,604	233,664		467,125	1,604	
017 NURSING ADMINISTRATIO	665	531,296		710,285	665	
018 MEDICAL RECORDS & LIB	4,180	441,966		711,991	4,180	
018 SOCIAL SERVICE	230			4,846	230	
018 01 UTILIZATION REVIEW	180	123,930		173,394	180	
025 INPAT ROUTINE SRVC CN						
025 ADULTS & PEDIATRICS	9,631	1,255,100		1,895,608	9,631	11,453
026 INTENSIVE CARE UNIT	2,841	746,331		1,055,995	2,841	4,901
033 NURSERY	474	114,871		160,194	474	
037 ANCILLARY SRVC COST C						
037 OPERATING ROOM	9,334	467,128		1,069,731	9,334	6,595
038 RECOVERY ROOM	2,295	119,824		209,484	2,295	
039 DELIVERY ROOM & LABOR	1,680	80,725		138,777	1,680	
040 ANESTHESIOLOGY		644,484		384,581		
041 RADIOLOGY-DIAGNDSTIC	3,139	535,515		1,014,663	3,139	994
041 01 NUCLEAR MEDICINE-DIAG	140			116,859	140	
041 02 CAT SCAN	1,320	126,403		520,943	1,320	
044 LABORATORY	2,472	611,942		1,958,889	2,472	
048 INTRAVENOUS THERAPY						
049 RESPIRATORY THERAPY	453	299,681		505,336	453	
050 PHYSICAL THERAPY	3,215	95,224		501,081	3,215	231
051 OCCUPATIONAL THERAPY		1,518		67,764		
052 SPEECH PATHOLOGY				8,582		
053 ELECTROCARDIOLOGY	100	42,689		144,818	100	
053 01 CARDIAC REHAB	723	72,443		107,590	723	
055 MEDICAL SUPPLIES CHAR		5,334		752,179		
055 30 IMPL. DEV. CHARGED TO				152,704		
056 DRUGS CHARGED TO PATI	776	117,170		3,837,390	776	
056 01 ONCOLOGY	4,875	293,528		499,558	4,875	309
060 OUTPAT SERVICE COST C						
060 CLINIC	162	43,988		62,493	162	1,168
061 EMERGENCY	6,004	923,572		1,645,233	6,004	8,852
062 OBSERVATION BEDS (NON						
062 SPEC PURPOSE COST CEN						
095 SUBTOTALS	85,622	10,494,131	-4,160,153	21,214,549	60,684	39,351
096 NONREIMBURS COST CENT						
096 GIFT, FLOWER, COFFEE	477			10,050	477	
098 PHYSICIANS' PRIVATE O	12,462	2,303,268		4,009,910	12,462	1,252
099 NONPAID WORKERS						
099 01 DME				1,098		
099 02 LACTATION CONSULTING						
099 03 DIABETIC COUNSELING						
100 VACANT SPACE	2,690			56,677	2,690	
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	2,133,321	3,815,134		4,160,153	1,702,467	168,710
104 (WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	21.069629				22.309004	
105 (WRKSHT B, PT I)		.298118		.164483		4.155112
105 COST TO BE ALLOCATED						
106 (WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
107 (WRKSHT B, PT II)						
107 COST TO BE ALLOCATED				285,703	256,245	18,003
108 (WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER				.011296	3.357816	.443391
108 (WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

	COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW
		(SQUARE FEET)	(MEALS SERVED)	(MANHOURS)	(DIRECT NRSNG HRS)	(TIME SPENT)	(PATIENT DAYS)	(PATIENT DAYS)
	GENERAL SERVICE COST	10	11	12	14	17	18	18.01
003	NEW CAP REL COSTS-BLD							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE							
008	OPERATION OF PLANT							
009	LAUNDRY & LINEN SERVI							
010	HOUSEKEEPING	75,075						
011	DIETARY	2,953	3,592					
012	CAFETERIA	1,604		29,177				
014	NURSING ADMINISTRATIO	665		1,044	13,644			
017	MEDICAL RECORDS & LIB	4,180		2,342		225,540		
018	SOCIAL SERVICE	230					3,592	
018	01 UTILIZATION REVIEW	180						3,592
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	9,631	2,933	4,435	4,435	57,565	2,933	2,933
026	INTENSIVE CARE UNIT	2,841	659	2,475	2,475	9,329	659	659
033	NURSERY	474		414	414	7,143		
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	9,334		2,119	1,676	46,563		
038	RECOVERY ROOM	2,295		277	277			
039	DELIVERY ROOM & LABOR	1,680		179	179			
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC	3,139		2,103		30,126		
041	01 NUCLEAR MEDICINE-DIAG	140						
041	02 CAT SCAN	1,320		535		4,128		
044	LABORATORY	2,472		2,721		5,735		
048	INTRAVENOUS THERAPY							
049	RESPIRATORY THERAPY	453		1,047				
050	PHYSICAL THERAPY	3,215				10,728		
051	OCCUPATIONAL THERAPY					687		
052	SPEECH PATHOLOGY					174		
053	ELECTROCARDIOLOGY	100		177		230		
053	01 CARDIAC REHAB	723		218	218			
055	MEDICAL SUPPLIES CHAR			505				
055	30 IMPL. DEV. CHARGED TO							
056	DRUGS CHARGED TO PATI	776		446				
056	01 ONCOLOGY	4,875		1,083	1,083	10,267		
	OUTPAT SERVICE COST C							
060	CLINIC	162		116	116			
061	EMERGENCY	6,004		2,771	2,771	41,415		
062	OBSERVATION BEDS (NON SPEC PURPOSE COST CEN							
095	SUBTOTALS	59,446	3,592	25,007	13,644	224,090	3,592	3,592
	NONREIMBURS COST CENT							
096	GIFT, FLOWER, COFFEE	477						
098	PHYSICIANS' PRIVATE O	12,462		4,170		1,450		
099	NONPAID WORKERS							
099	01 DME							
099	02 LACTATION CONSULTING							
099	03 DIABETIC COUNSELING							
100	VACANT SPACE	2,690						
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	621,355	366,312	593,018	868,673	1,004,550	12,678	207,420
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	8.276457	101.979955	20.324845	63.667033	4.453977	3.529510	57.744989
105	COST TO BE ALLOCATED (WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)							
107	COST TO BE ALLOCATED (WRKSHT B, PART III)	20,629	76,581	44,900	26,057	114,903	5,736	6,405
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	.274779	21.319878	1.538883	1.909777	.509457	1.596882	1.783129

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET C
 I I TO 12/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	3,657,285		3,657,285		
26	INTENSIVE CARE UNIT	1,693,961		1,693,961		
33	NURSERY	267,627		267,627		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,915,736		1,915,736		
38	RECOVERY ROOM	337,400		337,400		
39	DELIVERY ROOM & LABOR ROO	228,020		228,020		
40	ANESTHESIOLOGY	447,838		447,838		
41	RADIOLOGY-DIAGNOSTIC	1,458,620		1,458,620		
41 01	NUCLEAR MEDICINE-DIAGNOST	140,362		140,362		
41 02	CAT SCAN	676,262		676,262		
44	LABORATORY	2,437,548		2,437,548		
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	623,590		623,590		
50	PHYSICAL THERAPY	730,574		730,574		
51	OCCUPATIONAL THERAPY	81,970		81,970		
52	SPEECH PATHOLOGY	10,769		10,769		
53	ELECTROCARDIOLOGY	176,318		176,318		
53 01	CARDIAC REHAB	165,710		165,710		
55	MEDICAL SUPPLIES CHARGED	886,164		886,164		
55 30	IMPL. DEV. CHARGED TO PAT	177,821		177,821		
56	DRUGS CHARGED TO PATIENTS	4,501,375		4,501,375		
56 01	ONCOLOGY	868,807		868,807		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	92,323		92,323		
61	EMERGENCY	2,553,464		2,553,464		
62	OBSERVATION BEDS (NON-DIS	786,360		786,360		
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	24,915,904		24,915,904		
102	LESS OBSERVATION BEDS	786,360		786,360		
103	TOTAL	24,129,544		24,129,544		

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET C
 I I TO 12/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	1,936,501		1,936,501			
26	INTENSIVE CARE UNIT	1,000,328		1,000,328			
33	NURSERY	221,835		221,835			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	473,703	2,492,990	2,966,693	.645748	.645748	
38	RECOVERY ROOM	70,789	383,544	454,333	.742627	.742627	
39	DELIVERY ROOM & LABOR ROO	342,616	153,733	496,349	.459394	.459394	
40	ANESTHESIOLOGY	64,506	158,426	222,932	2.008855	2.008855	
41	RADIOLOGY-DIAGNOSTIC	404,398	4,117,998	4,522,396	.322533	.322533	
41 01	NUCLEAR MEDICINE-DIAGNOST	33,289	390,566	423,855	.331156	.331156	
41 02	CAT SCAN	593,115	8,529,133	9,122,248	.074133	.074133	
44	LABORATORY	1,427,753	7,223,933	8,651,686	.281743	.281743	
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	731,229	441,851	1,173,080	.531584	.531584	
50	PHYSICAL THERAPY	312,222	1,020,468	1,332,690	.548195	.548195	
51	OCCUPATIONAL THERAPY	75,368	158,106	233,474	.351088	.351088	
52	SPEECH PATHOLOGY	10,435	27,668	38,103	.282629	.282629	
53	ELECTROCARDIOLOGY	33,558	770,230	803,788	.219359	.219359	
53 01	CARDIAC REHAB		132,406	132,406	1.251529	1.251529	
55	MEDICAL SUPPLIES CHARGED	759,449	1,122,561	1,882,010	.470860	.470860	
55 30	IMPL. DEV. CHARGED TO PAT	80,116	300,953	381,069	.466637	.466637	
56	DRUGS CHARGED TO PATIENTS	1,677,967	6,639,795	8,317,762	.541176	.541176	
56 01	ONCOLOGY	3,605	915,198	918,803	.945586	.945586	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	134	13,652	13,786	6.696866	6.696866	
61	EMERGENCY	121,170	3,951,406	4,072,576	.626990	.626990	
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	12,376	1,108,176	1,120,552	.701761	.701761	
101	SUBTOTAL	10,386,462	40,052,793	50,439,255			
102	LESS OBSERVATION BEDS						
103	TOTAL	10,386,462	40,052,793	50,439,255			

COMPUTATION OF RATIO OF COSTS TO CHARGES
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	3,657,285		3,657,285		
26	INTENSIVE CARE UNIT	1,693,961		1,693,961		
33	NURSERY	267,627		267,627		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,915,736		1,915,736		
38	RECOVERY ROOM	337,400		337,400		
39	DELIVERY ROOM & LABOR ROO	228,020		228,020		
40	ANESTHESIOLOGY	447,838		447,838		
41	RADIOLOGY-DIAGNOSTIC	1,458,620		1,458,620		
41	01 NUCLEAR MEDICINE-DIAGNOST	140,362		140,362		
41	02 CAT SCAN	676,262		676,262		
44	LABORATORY	2,437,548		2,437,548		
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	623,590		623,590		
50	PHYSICAL THERAPY	730,574		730,574		
51	OCCUPATIONAL THERAPY	81,970		81,970		
52	SPEECH PATHOLOGY	10,769		10,769		
53	ELECTROCARDIOLOGY	176,318		176,318		
53	01 CARDIAC REHAB	165,710		165,710		
55	MEDICAL SUPPLIES CHARGED	886,164		886,164		
55	30 IMPL. DEV. CHARGED TO PAT	177,821		177,821		
56	DRUGS CHARGED TO PATIENTS	4,501,375		4,501,375		
56	01 ONCOLOGY	868,807		868,807		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	92,323		92,323		
61	EMERGENCY	2,553,464		2,553,464		
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	786,360		786,360		
101	SUBTOTAL	24,915,904		24,915,904		
102	LESS OBSERVATION BEDS	786,360		786,360		
103	TOTAL	24,129,544		24,129,544		

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
I 15-1333 I FROM 1/ 1/2010 I WORKSHEET C
I I TO 12/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	1,936,501		1,936,501			
26	INTENSIVE CARE UNIT	1,000,328		1,000,328			
33	NURSERY	221,835		221,835			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	473,703	2,492,990	2,966,693	.645748	.645748	
38	RECOVERY ROOM	70,789	383,544	454,333	.742627	.742627	
39	DELIVERY ROOM & LABOR ROO	342,616	153,733	496,349	.459394	.459394	
40	ANESTHESIOLOGY	64,506	158,426	222,932	2.008855	2.008855	
41	RADIOLOGY-DIAGNOSTIC	404,398	4,117,998	4,522,396	.322533	.322533	
41 01	NUCLEAR MEDICINE-DIAGNOST	33,289	390,566	423,855	.331156	.331156	
41 02	CAT SCAN	593,115	8,529,133	9,122,248	.074133	.074133	
44	LABORATORY	1,427,753	7,223,933	8,651,686	.281743	.281743	
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	731,229	441,851	1,173,080	.531584	.531584	
50	PHYSICAL THERAPY	312,222	1,020,468	1,332,690	.548195	.548195	
51	OCCUPATIONAL THERAPY	75,368	158,106	233,474	.351088	.351088	
52	SPEECH PATHOLOGY	10,435	27,668	38,103	.282629	.282629	
53	ELECTROCARDIOLOGY	33,558	770,230	803,788	.219359	.219359	
53 01	CARDIAC REHAB		132,406	132,406	1.251529	1.251529	
55	MEDICAL SUPPLIES CHARGED	759,449	1,122,561	1,882,010	.470860	.470860	
55 30	IMPL. DEV. CHARGED TO PAT	80,116	300,953	381,069	.466637	.466637	
56	DRUGS CHARGED TO PATIENTS	1,677,967	6,639,795	8,317,762	.541176	.541176	
56 01	ONCOLOGY	3,605	915,198	918,803	.945586	.945586	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	134	13,652	13,786	6.696866	6.696866	
61	EMERGENCY	121,170	3,951,406	4,072,576	.626990	.626990	
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	12,376	1,108,176	1,120,552	.701761	.701761	
101	SUBTOTAL	10,386,462	40,052,793	50,439,255			
102	LESS OBSERVATION BEDS						
103	TOTAL	10,386,462	40,052,793	50,439,255			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,915,736	275,763	1,639,973			1,915,736
38	RECOVERY ROOM	337,400	60,013	277,387			337,400
39	DELIVERY ROOM & LABOR ROO	228,020	43,685	184,335			228,020
40	ANESTHESIOLOGY	447,838	4,344	443,494			447,838
41	RADIOLOGY-DIAGNOSTIC	1,458,620	108,028	1,350,592			1,458,620
41	01 NUCLEAR MEDICINE-DIAGNOST	140,362	4,778	135,584			140,362
41	02 CAT SCAN	676,262	41,418	634,844			676,262
44	LABORATORY	2,437,548	90,301	2,347,247			2,437,548
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	623,590	18,509	605,081			623,590
50	PHYSICAL THERAPY	730,574	90,644	639,930			730,574
51	OCCUPATIONAL THERAPY	81,970	1,115	80,855			81,970
52	SPEECH PATHOLOGY	10,769	186	10,583			10,769
53	ELECTROCARDIOLOGY	176,318	4,495	171,823			176,318
53	01 CARDIAC REHAB	165,710	19,826	145,884			165,710
55	MEDICAL SUPPLIES CHARGED	886,164	9,274	876,890			886,164
55	30 IMPL. DEV. CHARGED TO PAT	177,821	1,725	176,096			177,821
56	DRUGS CHARGED TO PATIENTS	4,501,375	63,202	4,438,173			4,501,375
56	01 ONCOLOGY	868,807	135,169	733,638			868,807
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	92,323	5,627	86,696			92,323
61	EMERGENCY	2,553,464	201,477	2,351,987			2,553,464
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	786,360		786,360			786,360
101	SUBTOTAL	19,297,031	1,179,579	18,117,452			19,297,031
102	LESS OBSERVATION BEDS	786,360		786,360			786,360
103	TOTAL	18,510,671	1,179,579	17,331,092			18,510,671

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	2,966,693	.645748	.645748
38	RECOVERY ROOM	454,333	.742627	.742627
39	DELIVERY ROOM & LABOR ROO	496,349	.459394	.459394
40	ANESTHESIOLOGY	222,932	2.008855	2.008855
41	RADIOLOGY-DIAGNOSTIC	4,522,396	.322533	.322533
41 01	NUCLEAR MEDICINE-DIAGNOST	423,855	.331156	.331156
41 02	CAT SCAN	9,122,248	.074133	.074133
44	LABORATORY	8,651,686	.281743	.281743
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	1,173,080	.531584	.531584
50	PHYSICAL THERAPY	1,332,690	.548195	.548195
51	OCCUPATIONAL THERAPY	233,474	.351088	.351088
52	SPEECH PATHOLOGY	38,103	.282629	.282629
53	ELECTROCARDIOLOGY	803,788	.219359	.219359
53 01	CARDIAC REHAB	132,406	1.251529	1.251529
55	MEDICAL SUPPLIES CHARGED	1,882,010	.470860	.470860
55 30	IMPL. DEV. CHARGED TO PAT	381,069	.466637	.466637
56	DRUGS CHARGED TO PATIENTS	8,317,762	.541176	.541176
56 01	ONCOLOGY	918,803	.945586	.945586
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	13,786	6.696866	6.696866
61	EMERGENCY	4,072,576	.626990	.626990
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	1,120,552	.701761	.701761
101	SUBTOTAL	47,280,591		
102	LESS OBSERVATION BEDS	1,120,552		
103	TOTAL	46,160,039		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,915,736	275,763	1,639,973			1,915,736
38	RECOVERY ROOM	337,400	60,013	277,387			337,400
39	DELIVERY ROOM & LABOR ROO	228,020	43,685	184,335			228,020
40	ANESTHESIOLOGY	447,838	4,344	443,494			447,838
41	RADIOLOGY-DIAGNOSTIC	1,458,620	108,028	1,350,592			1,458,620
41 01	NUCLEAR MEDICINE-DIAGNOST	140,362	4,778	135,584			140,362
41 02	CAT SCAN	676,262	41,418	634,844			676,262
44	LABORATORY	2,437,548	90,301	2,347,247			2,437,548
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	623,590	18,509	605,081			623,590
50	PHYSICAL THERAPY	730,574	90,644	639,930			730,574
51	OCCUPATIONAL THERAPY	81,970	1,115	80,855			81,970
52	SPEECH PATHOLOGY	10,769	186	10,583			10,769
53	ELECTROCARDIOLOGY	176,318	4,495	171,823			176,318
53 01	CARDIAC REHAB	165,710	19,826	145,884			165,710
55	MEDICAL SUPPLIES CHARGED	886,164	9,274	876,890			886,164
55 30	IMPL. DEV. CHARGED TO PAT	177,821	1,725	176,096			177,821
56	DRUGS CHARGED TO PATIENTS	4,501,375	63,202	4,438,173			4,501,375
56 01	ONCOLOGY	868,807	135,169	733,638			868,807
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	92,323	5,627	86,696			92,323
61	EMERGENCY	2,553,464	201,477	2,351,987			2,553,464
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	786,360		786,360			786,360
101	SUBTOTAL	19,297,031	1,179,579	18,117,452			19,297,031
102	LESS OBSERVATION BEDS	786,360		786,360			786,360
103	TOTAL	18,510,671	1,179,579	17,331,092			18,510,671

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES 7	OUTPAT COST TO CHRGR RATIO 8	I/P PT B COST TO CHRGR RATIO 9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	2,966,693	.645748	.645748
38	RECOVERY ROOM	454,333	.742627	.742627
39	DELIVERY ROOM & LABOR ROO	496,349	.459394	.459394
40	ANESTHESIOLOGY	222,932	2.008855	2.008855
41	RADIOLOGY-DIAGNOSTIC	4,522,396	.322533	.322533
41 01	NUCLEAR MEDICINE-DIAGNOST	423,855	.331156	.331156
41 02	CAT SCAN	9,122,248	.074133	.074133
44	LABORATORY	8,651,686	.281743	.281743
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	1,173,080	.531584	.531584
50	PHYSICAL THERAPY	1,332,690	.548195	.548195
51	OCCUPATIONAL THERAPY	233,474	.351088	.351088
52	SPEECH PATHOLOGY	38,103	.282629	.282629
53	ELECTROCARDIOLOGY	803,788	.219359	.219359
53 01	CARDIAC REHAB	132,406	1.251529	1.251529
55	MEDICAL SUPPLIES CHARGED	1,882,010	.470860	.470860
55 30	IMPL. DEV. CHARGED TO PAT	381,069	.466637	.466637
56	DRUGS CHARGED TO PATIENTS	8,317,762	.541176	.541176
56 01	ONCOLOGY	918,803	.945586	.945586
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	13,786	6.696866	6.696866
61	EMERGENCY	4,072,576	.626990	.626990
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	1,120,552	.701761	.701761
101	SUBTOTAL	47,280,591		
102	LESS OBSERVATION BEDS	1,120,552		
103	TOTAL	46,160,039		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET C
 I I TO 12/31/2010 I PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,915,736	2,966,693			
38	RECOVERY ROOM	337,400	454,333			
39	DELIVERY ROOM & LABOR ROO	228,020	496,349			
40	ANESTHESIOLOGY	447,838	222,932			
41	RADIOLOGY-DIAGNOSTIC	1,458,620	4,522,396			
41	01 NUCLEAR MEDICINE-DIAGNOST	140,362	423,855			
41	02 CAT SCAN	676,262	9,122,248			
44	LABORATORY	2,437,548	8,651,686			
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	623,590	1,173,080			
50	PHYSICAL THERAPY	730,574	1,332,690			
51	OCCUPATIONAL THERAPY	81,970	233,474			
52	SPEECH PATHOLOGY	10,769	38,103			
53	ELECTROCARDIOLOGY	176,318	803,788			
53	01 CARDIAC REHAB	165,710	132,406			
55	MEDICAL SUPPLIES CHARGED	886,164	1,882,010			
55	30 IMPL. DEV. CHARGED TO PAT	177,821	381,069			
56	DRUGS CHARGED TO PATIENTS	4,501,375	8,317,762			
56	01 ONCOLOGY	868,807	918,803			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	92,323	13,786			
61	EMERGENCY	2,553,464	4,072,576			
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	786,360	1,120,552			
101	TOTAL	19,297,031	47,280,591			

COMPUTATION OF OUTPATIENT COST PER VISIT -
RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
I 15-1333 I FROM 1/ 1/2010 I WORKSHEET C
I I TO 12/31/2010 I PART V

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT- PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT- PATIENT COSTS 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM	1,915,736		1,915,736	2,966,693			
38	RECOVERY ROOM	337,400		337,400	454,333			
39	DELIVERY ROOM & LABOR ROO	228,020		228,020	496,349			
40	ANESTHESIOLOGY	447,838	374,790	822,628	222,932			
41	RADIOLOGY-DIAGNOSTIC	1,458,620		1,458,620	4,522,396			
41	01 NUCLEAR MEDICINE-DIAGNOST	140,362		140,362	423,855			
41	02 CAT SCAN	676,262		676,262	9,122,248			
44	LABORATORY	2,437,548		2,437,548	8,651,686			
48	INTRAVENOUS THERAPY							
49	RESPIRATORY THERAPY	623,590		623,590	1,173,080			
50	PHYSICAL THERAPY	730,574		730,574	1,332,690			
51	OCCUPATIONAL THERAPY	81,970		81,970	233,474			
52	SPEECH PATHOLOGY	10,769		10,769	38,103			
53	ELECTROCARDIOLOGY	176,318		176,318	803,788			
53	01 CARDIAC REHAB	165,710	1,320	167,030	132,406			
55	MEDICAL SUPPLIES CHARGED	886,164		886,164	1,882,010			
55	30 IMPL. DEV. CHARGED TO PAT	177,821		177,821	381,069			
56	DRUGS CHARGED TO PATIENTS	4,501,375		4,501,375	8,317,762			
56	01 ONCOLOGY	868,807	215,397	1,084,204	918,803			
	OUTPAT SERVICE COST CNTRS							
60	CLINIC	92,323		92,323	13,786			
61	EMERGENCY	2,553,464	1,134,800	3,688,264	4,072,576			
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	786,360		786,360	1,120,552			
101	TOTAL	19,297,031	1,726,307	21,023,338	47,280,591			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART V
 I 15-1333 I I

TITLE XVIII, PART B

HOSPITAL

Cost/Charge
Ratio (C, Pt I,
col. 9)

Cost/Charge
Ratio (C, Pt I,
col. 9)

Cost/Charge
Ratio (C, Pt
II, col. 9)

Outpatient
Ambulatory
Surgical Ctr

Outpatient
Radiology

Cost Center Description

1

1.01

1.02

2

3

(A)	ANCILLARY SRVC COST CNTRS				
37	OPERATING ROOM	.645748		.645748	
38	RECOVERY ROOM	.742627		.742627	
39	DELIVERY ROOM & LABOR ROOM	.459394		.459394	
40	ANESTHESIOLOGY	2.008855		2.008855	
41	RADIOLOGY-DIAGNOSTIC	.322533		.322533	
41 01	NUCLEAR MEDICINE-DIAGNOSTIC	.331156		.331156	
41 02	CAT SCAN	.074133		.074133	
44	LABORATORY	.281743		.281743	
48	INTRAVENOUS THERAPY				
49	RESPIRATORY THERAPY	.531584		.531584	
50	PHYSICAL THERAPY	.548195		.548195	
51	OCCUPATIONAL THERAPY	.351088		.351088	
52	SPEECH PATHOLOGY	.282629		.282629	
53	ELECTROCARDIOLOGY	.219359		.219359	
53 01	CARDIAC REHAB	1.251529		1.251529	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.470860		.470860	
55 30	IMPL. DEV. CHARGED TO PATIENT	.466637		.466637	
56	DRUGS CHARGED TO PATIENTS	.541176		.541176	
56 01	ONCOLOGY	.945586		.945586	
	OUTPAT SERVICE COST CNTRS				
60	CLINIC	6.696866		6.696866	
61	EMERGENCY	.626990		.626990	
62	OBSERVATION BEDS (NON-DISTINCT PART)	.701761		.701761	
101	SUBTOTAL				
102	CRNA CHARGES				
103	LESS PBP CLINIC LAB SVCS-				
	PROGRAM ONLY CHARGES				
104	NET CHARGES				

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII, PART B

HOSPITAL

		Other Outpatient Diagnostic	All other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
Cost Center Description		4	5	6	7	8
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		688,590			
38	RECOVERY ROOM		90,690			
39	DELIVERY ROOM & LABOR ROOM		1,377			
40	ANESTHESIOLOGY		45,631			
41	RADIOLOGY-DIAGNOSTIC		1,039,395			
41 01	NUCLEAR MEDICINE-DIAGNOSTIC		120,141			
41 02	CAT SCAN		2,497,880			
44	LABORATORY		2,718,524			
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY		260,091			
50	PHYSICAL THERAPY		354,124			
51	OCCUPATIONAL THERAPY		52,899			
52	SPEECH PATHOLOGY		7,583			
53	ELECTROCARDIOLOGY		246,020			
53 01	CARDIAC REHAB		41,110			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		437,745			
55 30	IMPL. DEV. CHARGED TO PATIENT		45,580			
56	DRUGS CHARGED TO PATIENTS		2,981,456			
56 01	ONCOLOGY		157,567			
60	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY		963,698			
62	OBSERVATION BEDS (NON-DISTINCT PART)		488,579			
101	SUBTOTAL		13,238,680			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104	NET CHARGES		13,238,680			

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII, PART B		HOSPITAL		
		All other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
Cost Center Description		9	10	11
(A)	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	444,656		
38	RECOVERY ROOM	67,349		
39	DELIVERY ROOM & LABOR ROOM	633		
40	ANESTHESIOLOGY	91,666		
41	RADIOLOGY-DIAGNOSTIC	335,239		
41 01	NUCLEAR MEDICINE-DIAGNOSTIC	39,785		
41 02	CAT SCAN	185,175		
44	LABORATORY	765,925		
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	138,260		
50	PHYSICAL THERAPY	194,129		
51	OCCUPATIONAL THERAPY	18,572		
52	SPEECH PATHOLOGY	2,143		
53	ELECTROCARDIOLOGY	53,967		
53 01	CARDIAC REHAB	51,450		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	206,117		
55 30	IMPL. DEV. CHARGED TO PATIENT	21,269		
56	DRUGS CHARGED TO PATIENTS	1,613,492		
56 01	ONCOLOGY	148,993		
60	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	604,229		
62	OBSERVATION BEDS (NON-DISTINCT PART)	342,866		
101	SUBTOTAL	5,325,915		
102	CRNA CHARGES			
103	LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104	NET CHARGES	5,325,915		

(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 COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/24/2011
I	15-1333	I	FROM 1/ 1/2010	I	WORKSHEET D
I	COMPONENT NO:	I	TO 12/31/2010	I	PART VI
I	15-1333	I		I	

TITLE XVIII, PART B

HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES
2	PROGRAM VACCINE CHARGES
3	PROGRAM COSTS

1
.541176
1,003
543

COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/24/2011
I	15-1333	I	FROM 1/ 1/2010	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 12/31/2010	I	PART I
I	15-1333	I		I	

TITLE XVIII PART A	HOSPITAL	OTHER
--------------------	----------	-------

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,700
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,206
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,206
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	334
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	160
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,471
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	334
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	145.00
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,657,285
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	23,200
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	366,078
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,291,207

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,778,309
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,778,309
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.850751
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	554.68
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	3,291,207

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					1,026.58
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					1,510,099
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					1,510,099

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY) INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS				
43	1,693,961	659	2,570.50	406	1,043,623
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				
49	TOTAL PROGRAM INPATIENT COSTS				

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)	342,878
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	342,878
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

TITLE XVIII PART A HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	766
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,026.58
85	OBSERVATION BED COST	786,360

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,700
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,206
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,206
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	334
6	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)	
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	160
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	229
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	320
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,657,285
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	345,065
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,312,220

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,778,309
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,778,309
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.862567
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	554.68
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	3,312,220

TITLE XIX - I/P HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 1,033.13
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 236,587
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 236,587

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY) INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS	267,627	320	836.33		
43 INTENSIVE CARE UNIT	1,693,961	659	2,570.50		
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					1
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					225,088
49 TOTAL PROGRAM INPATIENT COSTS					461,675

PASS THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

TITLE XIX - I/P HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	766
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,033.13
85	OBSERVATION BED COST	791,378

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-1333 I

TITLE XVIII, PART A HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES	INPATIENT CHARGES	INPATIENT COST
		1	2	3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		1,048,719	
26	INTENSIVE CARE UNIT		571,959	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.645748	140,743	90,885
38	RECOVERY ROOM	.742627	26,149	19,419
39	DELIVERY ROOM & LABOR ROOM	.459394	911	419
40	ANESTHESIOLOGY	2.008855	10,916	21,929
41	RADIOLOGY-DIAGNOSTIC	.322533	190,390	61,407
41 01	NUCLEAR MEDICINE-DIAGNOSTIC	.331156	16,943	5,611
41 02	CAT SCAN	.074133	226,032	16,756
44	LABORATORY	.281743	672,076	189,353
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	.531584	270,100	143,581
50	PHYSICAL THERAPY	.548195	121,555	66,636
51	OCCUPATIONAL THERAPY	.351088	27,450	9,637
52	SPEECH PATHOLOGY	.282629	7,103	2,008
53	ELECTROCARDIOLOGY	.219359	16,182	3,550
53 01	CARDIAC REHAB	1.251529		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.470860	383,516	180,582
55 30	IMPL. DEV. CHARGED TO PATIENT	.466637	80,116	37,385
56	DRUGS CHARGED TO PATIENTS	.541176	847,230	458,501
56 01	ONCOLOGY	.945586	1,294	1,224
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	6.696866	134	897
61	EMERGENCY	.626990	928	582
62	OBSERVATION BEDS (NON-DISTINCT PART)	.701761		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		3,039,768	1,310,362
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		3,039,768	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-Z333 I I

TITLE XVIII, PART A

SWING BED SNF

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES	INPATIENT CHARGES	INPATIENT COST
		1	2	3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.645748		
38	RECOVERY ROOM	.742627		
39	DELIVERY ROOM & LABOR ROOM	.459394		
40	ANESTHESIOLOGY	2.008855		
41	RADIOLOGY-DIAGNOSTIC	.322533	6,104	1,969
41 01	NUCLEAR MEDICINE-DIAGNOSTIC	.331156		
41 02	CAT SCAN	.074133	12,527	929
44	LABORATORY	.281743	33,109	9,328
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	.531584	13,747	7,308
50	PHYSICAL THERAPY	.548195	87,866	48,168
51	OCCUPATIONAL THERAPY	.351088	29,960	10,519
52	SPEECH PATHOLOGY	.282629		
53	ELECTROCARDIOLOGY	.219359	317	70
53 01	CARDIAC REHAB	1.251529		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.470860	16,271	7,661
55 30	IMPL. DEV. CHARGED TO PATIENT	.466637		
56	DRUGS CHARGED TO PATIENTS	.541176	77,205	41,781
56 01	ONCOLOGY	.945586		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	6.696866		
61	EMERGENCY	.626990		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.701761		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		277,106	127,733
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		277,106	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-1333 I I

TITLE XIX

HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES	INPATIENT CHARGES	INPATIENT COST
		1	2	3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		174,348	
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS		16,012	
37	OPERATING ROOM	.645748	62,388	40,287
38	RECOVERY ROOM	.742627	5,734	4,258
39	DELIVERY ROOM & LABOR ROOM	.459394	67,728	31,114
40	ANESTHESIOLOGY	2.008855		
41	RADIOLOGY-DIAGNOSTIC	.322533	14,417	4,650
41 01	NUCLEAR MEDICINE-DIAGNOSTIC	.331156	466	154
41 02	CAT SCAN	.074133	23,699	1,757
44	LABORATORY	.281743	89,027	25,083
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	.531584	12,121	6,443
50	PHYSICAL THERAPY	.548195	5,797	3,178
51	OCCUPATIONAL THERAPY	.351088	851	299
52	SPEECH PATHOLOGY	.282629	3,332	942
53	ELECTROCARDIOLOGY	.219359	1,296	284
53 01	CARDIAC REHAB	1.251529		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.470860	69,745	32,840
55 30	IMPL. DEV. CHARGED TO PATIENT	.466637		
56	DRUGS CHARGED TO PATIENTS	.541176	108,848	58,906
56 01	ONCOLOGY	.945586		
60	OUTPAT SERVICE COST CNTRS CLINIC	6.696866		
61	EMERGENCY	.626990	9,901	6,208
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS	.701761	12,376	8,685
101	TOTAL		487,726	225,088
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		487,726	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/24/2011
I	15-1333	I	FROM 1/ 1/2010	I	WORKSHEET E
I	COMPONENT NO:	I	TO 12/31/2010	I	PART B
I	15-1333	I		I	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	5,326,458
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	OUTPATIENT ANCILLARY PASSTHRU COSTS FROM (W/S D,IV (COLS 9, 9.01, 9.02) LINE 101	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	5,326,458

COMPUTATION OF LESSER OF COST OR CHARGES

6	REASONABLE CHARGES	
7	ANCILLARY SERVICE CHARGES	
8	INTERNS AND RESIDENTS SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES	
10	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
11	TOTAL REASONABLE CHARGES	
12	CUSTOMARY CHARGES	
13	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
14	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).	
15	RATIO OF LINE 11 TO LINE 12	
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
19	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	5,379,723
20	17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

21	CAH DEDUCTIBLES	46,812
22	18.01 CAH ACTUAL BILLED COINSURANCE	2,114,144
23	LINE 17.01 (SEE INSTRUCTIONS)	
24	SUBTOTAL (SEE INSTRUCTIONS)	3,218,767
25	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
26	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
27	ESRD DIRECT MEDICAL EDUCATION COSTS	
28	SUBTOTAL	3,218,767
29	PRIMARY PAYER PAYMENTS	2,423
30	SUBTOTAL	3,216,344

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

31	COMPOSITE RATE ESRD	
32	BAD DEBTS (SEE INSTRUCTIONS)	372,391
33	27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	372,391
34	27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	338,085
35	SUBTOTAL	3,588,735
36	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
37	OTHER ADJUSTMENTS (SPECIFY)	
38	30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
39	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
40	SUBTOTAL	3,588,735
41	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
42	INTERIM PAYMENTS	3,713,708
43	34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
44	BALANCE DUE PROVIDER/PROGRAM	-124,973
45	35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	

TO BE COMPLETED BY CONTRACTOR

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-1333 I I

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3,474,676		3,554,250
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01	1/ 1/2010	33,802	1/ 1/2010	132,135
ADJUSTMENTS TO PROVIDER .02	8/ 5/2010	50,098	8/ 5/2010	138,006
ADJUSTMENTS TO PROVIDER .03	8/ 5/2010	1,657		
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROVIDER .49				
ADJUSTMENTS TO PROGRAM .50			8/ 5/2010	58,801
ADJUSTMENTS TO PROGRAM .51	12/23/2010	8,229	12/23/2010	51,882
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		77,328		159,458
4 TOTAL INTERIM PAYMENTS		3,552,004		3,713,708
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL .99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01			
	SETTLEMENT TO PROGRAM .02	5,878		124,973
7 TOTAL MEDICARE PROGRAM LIABILITY		3,546,126		3,588,735

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-Z333 I I

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				
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.		504,734		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01	8/ 5/2010	15,708		
ADJUSTMENTS TO PROVIDER .02	12/23/2010	14,244		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROVIDER .49				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		29,952		NONE
4 TOTAL INTERIM PAYMENTS		534,686		
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL .99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01			
	SETTLEMENT TO PROGRAM .02	69,132		
7 TOTAL MEDICARE PROGRAM LIABILITY		465,554		

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I
 I COMPONENT NO: I TO 12/31/2010 I WORKSHEET E-2
 I 15-2333 I I

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A 1	PART B 2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	346,307	
2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3 ANCILLARY SERVICES (SEE INSTRUCTIONS)	129,010	
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5 PROGRAM DAYS	334	
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8 SUBTOTAL	475,317	
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10 SUBTOTAL	475,317	
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12 SUBTOTAL	475,317	
13 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	9,763	
14 80% OF PART B COSTS		
15 SUBTOTAL	465,554	
16 OTHER ADJUSTMENTS (SPECIFY)		
17 REIMBURSABLE BAD DEBTS		
17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18 TOTAL	465,554	
19 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20 INTERIM PAYMENTS	534,686	
20.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21 BALANCE DUE PROVIDER/PROGRAM	-69,132	
22 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/24/2011
I	15-1333	I	FROM 1/ 1/2010	I	WORKSHEET E-3	
I	COMPONENT NO:	I	TO 12/31/2010	I	PART II	
I	15-1333	I		I		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES		3,864,084
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		
2	ORGAN ACQUISITION		
3	COST OF TEACHING PHYSICIANS		
4	SUBTOTAL		3,864,084
5	PRIMARY PAYER PAYMENTS		
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)		3,902,725
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
7	ROUTINE SERVICE CHARGES		
8	ANCILLARY SERVICE CHARGES		
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		
10	TEACHING PHYSICIANS		
11	TOTAL REASONABLE CHARGES		
CUSTOMARY CHARGES			
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)		
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS		
19	COST OF COVERED SERVICES		3,902,725
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)		418,412
21	EXCESS REASONABLE COST		
22	SUBTOTAL		3,484,313
23	COINSURANCE		9,075
24	SUBTOTAL		3,475,238
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))		70,888
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		70,888
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		59,439
26	SUBTOTAL		3,546,126
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION		
28	OTHER ADJUSTMENTS (SPECIFY)		
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
30	SUBTOTAL		3,546,126
31	SEQUESTRATION ADJUSTMENT		
32	INTERIM PAYMENTS		3,552,004
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
33	BALANCE DUE PROVIDER/PROGRAM		-5,878
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET E-3
 I COMPONENT NO: I TO 12/31/2010 I PART III
 I - I I

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

	TITLE XIX	HOSPITAL	OTHER TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
	COMPUTATION OF NET COST OF COVERED SERVICE			
1	INPATIENT HOSPITAL/SNF/NF SERVICES		461,675	
2	MEDICAL AND OTHER SERVICES			
3	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			
4	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)			
5	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			
6	SUBTOTAL		461,675	
7	INPATIENT PRIMARY PAYER PAYMENTS			
8	OUTPATIENT PRIMARY PAYER PAYMENTS			
9	SUBTOTAL		461,675	
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
10	ROUTINE SERVICE CHARGES		190,360	
11	ANCILLARY SERVICE CHARGES		487,726	
12	INTERNS AND RESIDENTS SERVICE CHARGES			
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE			
14	TEACHING PHYSICIANS			
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION			
16	TOTAL REASONABLE CHARGES		678,086	
	CUSTOMARY CHARGES			
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			
19	RATIO OF LINE 17 TO LINE 18			
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		678,086	
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		216,411	
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
23	COST OF COVERED SERVICES		461,675	
	PROSPECTIVE PAYMENT AMOUNT			
24	OTHER THAN OUTLIER PAYMENTS			
25	OUTLIER PAYMENTS			
26	PROGRAM CAPITAL PAYMENTS			
27	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS			
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS			
30	SUBTOTAL		461,675	
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)			
32	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE XVIII ENTER AMOUNT FROM LINE 30		461,675	
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34	EXCESS OF REASONABLE COST			
35	SUBTOTAL		461,675	
36	COINSURANCE			
37	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19			
38	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			
38.01	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING BEFORE 10/01/05 (SEE INSTRUCTIONS)			
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)			
39	UTILIZATION REVIEW			
40	SUBTOTAL (SEE INSTRUCTIONS)		461,675	
41	INPATIENT ROUTINE SERVICE COST			
42	MEDICARE INPATIENT ROUTINE CHARGES			
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT OF PART A SERVICES			
45	RATIO OF LINE 43 TO 44			
46	TOTAL CUSTOMARY CHARGES			
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			
50	OTHER ADJUSTMENTS (SPECIFY)			
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			
52	SUBTOTAL		461,675	
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER		461,675	
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
57	INTERIM PAYMENTS		209,945	
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/24/2011
I	15-1333	I	FROM 1/ 1/2010	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 12/31/2010	I	PART III
I	-	I		I	

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

TITLE XIX

HOSPITAL

OTHER
TITLE V OR
TITLE XIX

TITLE XVIII
SNF PPS

58 BALANCE DUE PROVIDER/PROGRAM
 59 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)
 IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.

1
251,730

2

BALANCE SHEET

I
I
I

PROVIDER NO:
15-1333

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

I PREPARED 5/24/2011
I
I WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	477,118			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	4,585,783			
5	OTHER RECEIVABLES	324,837			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7	INVENTORY	1,227,310			
8	PREPAID EXPENSES	362,441			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	6,977,489			
FIXED ASSETS					
12	LAND				
12.01	LAND IMPROVEMENTS	456,842			
13	LESS ACCUMULATED DEPRECIATION	-225,227			
13.01	BUILDINGS	28,540,047			
14	LESS ACCUMULATED DEPRECIATION	-14,543,654			
14.01	LEASEHOLD IMPROVEMENTS				
15	LESS ACCUMULATED DEPRECIATION				
15.01	FIXED EQUIPMENT				
16	LESS ACCUMULATED DEPRECIATION				
16.01	AUTOMOBILES AND TRUCKS				
17	LESS ACCUMULATED DEPRECIATION				
17.01	MAJOR MOVABLE EQUIPMENT	13,725,679			
18	LESS ACCUMULATED DEPRECIATION	-11,507,181			
18.01	MINOR EQUIPMENT DEPRECIABLE				
19	LESS ACCUMULATED DEPRECIATION				
19.01	MINOR EQUIPMENT-NONDEPRECIABLE				
20	TOTAL FIXED ASSETS	16,446,506			
21	OTHER ASSETS				
22	INVESTMENTS	2,326,830			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	3,186,543			
26	TOTAL OTHER ASSETS	5,513,373			
27	TOTAL ASSETS	28,937,368			

BALANCE SHEET

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/24/2011
I	15-1333	I	FROM 1/ 1/2010	I		
I		I	TO 12/31/2010	I	WORKSHEET G	

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE				
29 SALARIES, WAGES & FEES PAYABLE	2,006,215			
30 PAYROLL TAXES PAYABLE	80,702			
31 NOTES AND LOANS PAYABLE (SHORT TERM)	2,718			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	879,105			
36 TOTAL CURRENT LIABILITIES	2,968,740			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	11,806,359			
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	11,806,359			
43 TOTAL LIABILITIES	14,775,099			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	14,162,269			
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	14,162,269			
52 TOTAL LIABILITIES AND FUND BALANCES	28,937,368			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		16,733,461		
2 NET INCOME (LOSS)		-2,635,818		
3 TOTAL		14,097,643		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADDITIONS (CREDIT ADJUSTM	64,626			
6				
7				
8				
9				
10 TOTAL ADDITIONS		64,626		
11 SUBTOTAL		14,162,269		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM				
14				
15				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		14,162,269		

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	2,115,327		2,115,327
4 00 SWING BED - SNF	112,072		112,072
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	2,227,399		2,227,399
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT	2,051,818		2,051,818
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	2,051,818		2,051,818
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	4,279,217		4,279,217
17 00 ANCILLARY SERVICES	7,409,199	36,045,268	43,454,467
18 00 OUTPATIENT SERVICES	191,999	11,519,166	11,711,165
24 00			
25 00 TOTAL PATIENT REVENUES	11,880,415	47,564,434	59,444,849

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		31,784,487	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		31,784,487	

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/24/2011
 I 15-1333 I FROM 1/ 1/2010 I WORKSHEET G-3
 I I TO 12/31/2010 I

DESCRIPTION

1	TOTAL PATIENT REVENUES	59,444,849
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	30,591,412
3	NET PATIENT REVENUES	28,853,437
4	LESS: TOTAL OPERATING EXPENSES	31,784,487
5	NET INCOME FROM SERVICE TO PATIENTS	-2,931,050
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER OPERATING REVENUE	205,187
24.01	NON OPERATING INCOME	90,045
25	TOTAL OTHER INCOME	295,232
26	TOTAL	-2,635,818
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	-2,635,818