

**ADAMS MEMORIAL HOSPITAL  
DECATUR, INDIANA**

**PROVIDER NOS. 15-1330, 15-M330, 15-Z330,  
15-5316 AND 15-7172**

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

**DECEMBER 31, 2010**

ADAMS MEMORIAL HOSPITAL

PROVIDER NOS. 15-1330, 15-M330, 15-Z330, 15-5316 AND 15-7172

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Accountants' Disclaimer

Hospital Statements of Reimbursable Cost



Board of Trustees  
Adams Memorial Hospital  
Decatur, Indiana

In accordance with your request, we have compiled the Hospital Statements of Reimbursable Cost (Title XVIII and Title XIX) of Adams Memorial Hospital (Provider Nos. 15-1330, 15-M330, 15-Z330, 15-5316 and 15-7172) for the period ended December 31, 2010 in the accompanying prescribed form in accordance with Statements on Standards for Accounting Review Services issued by the American Institute of Certified Public Accountants.

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

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

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

*Bradley Associates*

May 17, 2011

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

FORM APPROVED  
 OMB NO. 0938-0050

WORKSHEET S  
 PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	I	15-1330	I	FROM 1/ 1/2010	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 12/31/2010	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/27/2011 TIME 13:00

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:  
 ADAMS MEMORIAL HOSPITAL 15-1330  
 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.

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 ECR ENCRYPTION INFORMATION  
 DATE: 5/27/2011 TIME 13:00

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 PI ENCRYPTION INFORMATION  
 DATE: 5/27/2011 TIME 13:00

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 NOKQe0gjYmk1piTinks1erG0eqAjuN  
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\_\_\_\_\_  
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

\_\_\_\_\_  
 TITLE

\_\_\_\_\_  
 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2	3	4	5	
1	HOSPITAL	0	-780,039	-342,492	0	0
2	SUBPROVIDER	0	0	0	0	0
3	SWING BED - SNF	0	0	0	0	0
5	HOSPITAL-BASED SNF	0	0	0	0	0
7	HOSPITAL-BASED HHA	0	0	0	0	0
100	TOTAL	0	-780,039	-342,492	0	0

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

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

MCRIF32 1.23.0.9 ~ 2552-96 25.0.123.1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 1100 MERCER AVENUE P.O. BOX:  
 1.01 CITY: DECATUR STATE: IN ZIP CODE: 46733- COUNTY: ADAMS

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N)		
					V	XVIII	XIX
02.00	HOSPITAL	15-1330	2.01	11/ 1/2005	N	O	P
03.00	SUBPROVIDER	ADAMS MEMORIAL HOSPITAL	15-M330	11/ 1/2005	N	P	P
04.00	SWING BED - SNF	ADAMS MEMORIAL HOSPITAL	15-Z330	11/ 1/2005	N	O	P
06.00	HOSPITAL-BASED SNF	ADAMS MEMORIAL HOSPITAL	15-5316	3/ 8/1988	N	P	N
09.00	HOSPITAL-BASED HHA	ADAMS MEMORIAL HOSPITAL	15-7172	1/ 1/1992	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 4

OTHER INFORMATION

- 21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.
- 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. N N
- 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
- 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 N 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. 2 N
- 22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N
- 23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N
- 23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. / / / /
- 23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY) / /
- 24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). / /

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? N

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

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

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

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

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

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

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

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

25.09 0000 0.00

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

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

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

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

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

28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. 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	100	0.8529	0.8391	
	0.00	0	15	15

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

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

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

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

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

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

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

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

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

31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). 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) N XVIII XIX  
 36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE  
 WITH 42 CFR 412.320? (SEE INSTRUCTIONS) N 2 3  
 37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N  
 37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE? N N N

TITLE XIX INPATIENT SERVICES

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

40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10?  
 IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME  
 OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS). Y 15H060

40.01 NAME: ADAMS HEALTH NETWORK FI/CONTRACTOR NAME NGS FI/CONTRACTOR #  
 40.02 STREET: 1100 MERCER AVE P.O. BOX:  
 40.03 CITY: DECATUR STATE: IN ZIP CODE: 46733-

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

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

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	1	2	3	4	5
47.00 HOSPITAL	N	N	N	N	N
48.00 SUBPROVIDER	N	N	N	N	N
49.00 SNF	N	N			
50.00 HHA	N	N			

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

	DATE	Y	OR	N	LIMIT	Y	OR	N	FEES
	0	1	2	3	4	5	6	7	8
56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.				N	0.00				0
56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.					0.00				0
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.					0.00				0
56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.					0.00				0
57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?				N					
58 ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.				N					
58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).									
59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)				N					
60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)				Y	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).				N				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.

HOSPITAL AND HOSPITAL HEALTH CARE  
COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
I 15-1330 I FROM 1/ 1/2010 I WORKSHEET S-3  
I TO 12/31/2010 I PART I

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	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	21	7,665	131,088.00		3,598		304
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	21	7,665	131,088.00		3,598		304
6 INTENSIVE CARE UNIT	4	1,460	17,544.00		345		81
11 NURSERY							122
12 TOTAL	25	9,125	148,632.00		3,943		507
13 RPCH VISITS							
14 SUBPROVIDER	10	3,650			56		209
15 SKILLED NURSING FACILITY	15	5,475			2,753		
18 HOME HEALTH AGENCY					3,107		1,105
20 AMBULATORY SURGICAL CENTER (							
21 HOSPICE							
25 TOTAL	50						
26 OBSERVATION BED DAYS							
26 01 OBSERVATION BED DAYS-SUB I							
27 AMBULANCE TRIPS					1,024		
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	NOT ADMITTED 6.02	INTERNS & RES. FTES TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			5,462				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF			40				
5 TOTAL ADULTS AND PEDS			5,502				
6 INTENSIVE CARE UNIT			731				
11 NURSERY			366				
12 TOTAL			6,599				
13 RPCH VISITS							
14 SUBPROVIDER			2,333				
15 SKILLED NURSING FACILITY			4,284				
18 HOME HEALTH AGENCY			7,892				
20 AMBULATORY SURGICAL CENTER (							
21 HOSPICE							
25 TOTAL							
26 OBSERVATION BED DAYS			879				
26 01 OBSERVATION BED DAYS-SUB I							
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					816	72	1,685
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		327.83			816	72	1,685
13 RPCH VISITS							
14 SUBPROVIDER		19.48			7	55	421
15 SKILLED NURSING FACILITY		18.56					
18 HOME HEALTH AGENCY		12.39					
20 AMBULATORY SURGICAL CENTER (							
21 HOSPICE							
25 TOTAL		378.26					
26 OBSERVATION BED DAYS							
26 01 OBSERVATION BED DAYS-SUB I							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET S-4  
 I HHA NO: I TO 12/31/2010 I  
 I 15-7172 I  
 COUNTY: I

HOSPITAL-BASED HOME HEALTH AGENCY  
 STATISTICAL DATA

HOME HEALTH AGENCY STATISTICAL DATA

HHA 1

	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4
1 HOME HEALTH AIDE HOURS	0	747	0	1,684
2 UNDUPLICATED CENSUS COUNT		149.00		188.00
	TOTAL 5			
1 HOME HEALTH AIDE HOURS	2,431			
2 UNDUPLICATED CENSUS COUNT	337.00			
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)				
ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK				
	40.00			
HHA NO. OF FTE EMPLOYEES (2080 HRS)				
	STAFF 1	CONTRACT 2	TOTAL 3	
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)	1.84		1.84	
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)				
5 OTHER ADMINISTRATIVE PERSONEL	2.75		2.75	
6 DIRECTING NURSING SERVICE	6.63		6.63	
7 NURSING SUPERVISOR				
8 PHYSICAL THERAPY SERVICE				
9 PHYSICAL THERAPY SUPERVISOR				
10 OCCUPATIONAL THERAPY SERVICE				
11 OCCUPATIONAL THERAPY SUPERVISOR				
12 SPEECH PATHOLOGY SERVICE				
13 SPEECH PATHOLOGY SUPERVISOR				
14 MEDICAL SOCIAL SERVICE				
15 MEDICAL SOCIAL SERVICE SUPERVISOR				
16 HOME HEALTH AIDE	1.17		1.17	
17 HOME HEALTH AIDE SUPERVISOR				
18				
HOME HEALTH AGENCY MSA CODES				
	1	1.01		
19 HOW MANY MSAs IN COL. 1 OR CBSAs IN COL. 1.01 DID YOU PROVIDER SERVICES TO DURING THE C/R PERIOD?	0	2		
20 LIST THOSE MSA CODE(S) IN COL. 1 & CBSA CODE(S) IN COL. 1.01 SERVICED DURING THIS C/R PERIOD (LINE 20 CONTAINS THE FIRST CODE).		23060		
20.01		99915		

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON  
 OR AFTER OCTOBER 1, 2000

	FULL EPISODES		LUPA EPISODES 3	PEP ONLY EPISODES 4
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2		
21 SKILLED NURSING VISITS	1,675	65	45	28
22 SKILLED NURSING VISIT CHARGES	234,500	9,100	6,300	3,920
23 PHYSICAL THERAPY VISITS	426	0	2	6
24 PHYSICAL THERAPY VISIT CHARGES	77,319	0	363	1,089
25 OCCUPATIONAL THERAPY VISITS	58	0	1	1
26 OCCUPATIONAL THERAPY VISIT CHARGES	12,325	0	213	213
27 SPEECH PATHOLOGY VISITS	75	0	0	0
28 SPEECH PATHOLOGY VISIT CHARGES	15,938	0	0	0
29 MEDICAL SOCIAL SERVICE VISITS	0	0	0	0
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0	0
31 HOME HEALTH AIDE VISITS	715	0	3	7
32 HOME HEALTH AIDE VISIT CHARGES	55,055	0	231	539
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	2,949	65	51	42
34 OTHER CHARGES	0	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	395,137	9,100	7,107	5,761
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	196	0	20	3
37 TOTAL NUMBER OF OUTLIER EPISODES	0	1	0	0
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	7,871	331	276	62

HOSPITAL-BASED HOME HEALTH AGENCY  
 STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET S-4  
 I HHA NO: I TO 12/31/2010 I  
 I 15-7172 I  
 COUNTY: I

HOME HEALTH AGENCY STATISTICAL DATA

HHA 1

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON  
 OR AFTER OCTOBER 1, 2000

	SCIC WITHIN A PEP 5	SCIC ONLY EPISODES 6	TOTAL (COLS. 1-6) 7
21 SKILLED NURSING VISITS	0	0	1,813
22 SKILLED NURSING VISIT CHARGES	0	0	253,820
23 PHYSICAL THERAPY VISITS	0	0	434
24 PHYSICAL THERAPY VISIT CHARGES	0	0	78,771
25 OCCUPATIONAL THERAPY VISITS	0	0	60
26 OCCUPATIONAL THERAPY VISIT CHARGES	0	0	12,751
27 SPEECH PATHOLOGY VISITS	0	0	75
28 SPEECH PATHOLOGY VISIT CHARGES	0	0	15,938
29 MEDICAL SOCIAL SERVICE VISITS	0	0	0
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0
31 HOME HEALTH AIDE VISITS	0	0	725
32 HOME HEALTH AIDE VISIT CHARGES	0	0	55,825
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	0	0	3,107
34 OTHER CHARGES	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	0	0	417,105
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	0	0	219
37 TOTAL NUMBER OF OUTLIER EPISODES	0	0	1
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	0	0	8,540

PROSPECTIVE PAYMENT FOR SNF  
STATISTICAL DATA

I PROVIDER NO: 15-1330  
I PERIOD: FROM 1/1/2010 TO 12/31/2010  
I PREPARED 5/27/2011  
I WORKSHEET S-7

GROUP(1)	M3PT REVENUE CODE	SERVICES RATE	PRIOR TO 10/1 DAYS	SERVICES RATE	ON/AFTER 10/1 DAYS	SRVCS 4/1/01 TO 9/30/01 RATE	DAYS
1	2	3	3.01	4	4.01	4.02	4.03
1	RUC						
2	RUB						
3	RUA						
3 .01	RUX						
3 .02	RUL						
4	RVC		8				
5	RVB		39				
6	RVA		11				
6 .01	RVX						
6 .02	RVL		4				
7	RHC		201				
8	RHB		164				
9	RHA		89				
9 .01	RHX		3				
9 .02	RHL						
10	RMC		67				
11	RMB		310				
12	RMA		102				
12 .01	RMX		631				
12 .02	RML		470				
13	RLB						
14	RLA						
14 .01	RLX						
15	SE3		233				
16	SE2		152				
17	SE1		30				
18	SSC		107				
19	SSB						
20	SSA		59				
21	CC2						
22	CC1						
23	CB2						
24	CB1		21				
25	CA2						
26	CA1		11				
27	IB2						
28	IB1						
29	IA2						
30	IA1						
31	BB2						
32	BB1						
33	BA2						
34	BA1						
35	PE2						
36	PE1						
37	PD2						
38	PD1						
39	PC2						
40	PC1		8				
41	PB2						
42	PB1						
43	PA2						
44	PA1						
45	AAA						
45 .01	ES3						
45 .02	ES2						
45 .03	ES1						
45 .04	HE2						
45 .05	HE1		6				
45 .06	HD2						
45 .07	HD1		20				
45 .08	HC2						
45 .09	HC1						
45 .10	HB2						
45 .11	HB1		7				
45 .12	LE2						
45 .13	LE1						
45 .14	LD2						
45 .15	LD1						
45 .16	LC2						
45 .17	LC1						
45 .18	LB2						
45 .19	LB1						
45 .20	CE2						
45 .21	CE1						
45 .22	CD2						
45 .23	CD1						
46	TOTAL		2,753				

(1) Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on after October 1st. Enter in column 4.03 the days on 4/1/2001 through 9/30/2001. The sum of the days in column 3.01, 4.01, and 4.03 must agree with the days reported on Wkst. S-3, Part I, column 4, line 15. The sum of the days in column 4.06 must agree with the days reported on Wkst S-3, Part I column 4, line 3.

PROSPECTIVE PAYMENT FOR SNF  
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
I 15-1330 I FROM 1/ 1/2010 I WORKSHEET S-7  
I I TO 12/31/2010 I

GROUP(1)	M3PI REVENUE CODE	SERVICES PRIOR TO 10/1 RATE	DAYS 3.01	SERVICES ON/AFTER 10/1 RATE	DAYS 4.01	SRVCS 4/1/01 TO 9/30/01 RATE	DAYS 4.03
1	2	3	3.01	4	4.01	4.02	4.03

Worksheet S-2 reference data:

Transition Period : 100% Federal  
Wage Index Factor (before 10/01): 0.8529  
Wage Index Factor (after 10/01) : 0.8391  
SNF Facility Specific Rate : 0.00  
Urban/Rural Designation : NOT SPECIFIED  
SNF MSA Code : 15  
SNF CBSA Code : 15

GROUP(1)	M3PI REVENUE CODE	HIGH COST(2) RUGS DAYS	SWING BED SNF DAYS	TOTAL 5
1	RUC	4.05	4.06	5
2	RUB			
3	RUA			
3 .01	RUX			
3 .02	RUL			
4	RVC			
5	RVB			
6	RVA			
6 .01	RVX			
6 .02	RVL			
7	RHC			
8	RHB			
9	RHA			
9 .01	RHX			
9 .02	RHL			
10	RMC			
11	RMB			
12	RMA			
12 .01	RMX			
12 .02	RML			
13	RLB			
14	RLA			
14 .01	RLX			
15	SE3			
16	SE2			
17	SE1			
18	SSC			
19	SSB			
20	SSA			
21	CC2			
22	CC1			
23	CB2			
24	CB1			
25	CA2			
26	CA1			
27	IB2			
28	IB1			
29	IA2			
30	IA1			
31	BB2			
32	BB1			
33	BA2			
34	BA1			
35	PE2			
36	PE1			
37	PD2			
38	PD1			
39	PC2			
40	PC1			
41	PB2			
42	PB1			
43	PA2			
44	PA1			
45	AAA			
45 .01	ES3			
45 .02	ES2			
45 .03	ES1			
45 .04	HE2			
45 .05	HE1			
45 .06	HD2			
45 .07	HD1			
45 .08	HC2			
45 .09	HC1			
45 .10	HB2			
45 .11	HB1			
45 .12	LE2			
45 .13	LE1			
45 .14	LD2			
45 .15	LD1			
45 .16	LC2			
45 .17	LC1			

PROSPECTIVE PAYMENT FOR SNF  
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
I 15-1330 I FROM 1/ 1/2010 I WORKSHEET S-7  
I I TO 12/31/2010 I

	GROUP(1)	M3PI REVENUE CODE	HIGH COST(2)		SWING BED SNF DAYS	TOTAL
			RUGS	DAYS		
	1	2	4.05		4.06	5
45	.18	LB2				
45	.19	LB1				
45	.20	CE2				
45	.21	CE1				
45	.22	CD2				
45	.23	CD1				
46		TOTAL				

(2) Enter in column 4.05 those days in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs will be incremented by an additional 20% payment.

(3) Enter in column 4.06 the swing bed days for cost reporting periods beginning on or after 7/1/2002.

(4) Additional Rugs were published in the "Federal Register", Vol. 74 No. 153 August 11,2009, page 40286. FY 2010 SNF Final Rule These RUGs are effective for services on or after 10/01/2010.

NOTE: The default line code designation has been changed to "AAA".

Worksheet S-2 reference data:  
 Transition Period : 100% Federal  
 Wage Index Factor (before 10/01): 0.8529  
 Wage Index Factor (after 10/01) : 0.8391  
 SNF Facility Specific Rate : 0.00  
 Urban/Rural Designation : NOT SPECIFIED  
 SNF MSA Code : 15  
 SNF CBSA Code : 15

HOSPITAL UNCOMPENSATED CARE DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET S-10  
 I I TO 12/31/2010 I  
 I I I

DESCRIPTION

UNCOMPENSATED CARE INFORMATION		
1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	
2.01	IS IT AT THE TIME OF ADMISSION?	
2.02	IS IT AT THE TIME OF FIRST BILLING?	
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	
2.04		
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	
4	ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	
5	ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?	
6	ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?	
7	ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?	
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?	
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04	
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	
14	IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02	
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?	
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	
UNCOMPENSATED CARE REVENUES		
17	REVENUE FROM UNCOMPENSATED CARE	3,815,797
17.01	GROSS MEDICAID REVENUES	1,399,072
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	100,000
20	RESTRICTED GRANTS	
21	NON-RESTRICTED GRANTS	
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	5,314,869
UNCOMPENSATED CARE COST		
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103)	.381873
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)	
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	200,000
27	TOTAL SCHIP COST, (LINE 24 * LINE 26)	76,375
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	7,094,682

HOSPITAL UNCOMPENSATED CARE DATA

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/27/2011
I	15-1330	I	FROM 1/ 1/2010	I	WORKSHEET S-10
I		I	TO 12/31/2010	I	
I		I		I	

DESCRIPTION

29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	2,709,267
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	9,138,251
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	3,489,651
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29)	2,785,642

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET A  
 I I TO 12/31/2010 I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3 0300	NEW CAP REL COSTS-BLDG & FIXT		1,437,737	1,437,737	75,760	1,513,497
4 0400	NEW CAP REL COSTS-MVBLE EQUIP					
4.01 0401	NEW CAP REL COSTS-RENTAL		2,369,695	2,369,695		2,369,695
5 0500	EMPLOYEE BENEFITS		6,292,945	6,292,945		6,292,945
6 0600	ADMINISTRATIVE & GENERAL	762,716	5,044,164	5,806,880	-71,874	5,735,006
8 0800	OPERATION OF PLANT	375,939	650,870	1,026,809		1,026,809
8.01 0801	BIO-MEDICAL	51,901	46,857	98,758		98,758
8.02 0802	UTILITIES - HOSPITAL		514,391	514,391	5,124	519,515
8.03 0803	UTILITIES - OFFSITE BLDGS		87,812	87,812	-5,124	82,688
9 0900	LAUNDRY & LINEN SERVICE	37,511	138,138	175,649		175,649
10 1000	HOUSEKEEPING	402,437	89,615	492,052		492,052
11 1100	DIETARY	580,524	555,527	1,136,051	-903,047	233,004
12 1200	CAFETERIA				903,047	903,047
14 1400	NURSING ADMINISTRATION	732,250	139,254	871,504		871,504
15 1500	CENTRAL SERVICES & SUPPLY					
16 1600	PHARMACY					
17 1700	MEDICAL RECORDS & LIBRARY	439,278	112,058	551,336		551,336
	INPAT ROUTINE SRVC CNTRS					
25 2500	ADULTS & PEDIATRICS	1,223,157	162,178	1,385,335	317,161	1,702,496
26 2600	INTENSIVE CARE UNIT	526,653	12,833	539,486		539,486
31 3100	SUBPROVIDER	1,010,724	167,776	1,178,500	-179,085	999,415
33 3300	NURSERY				170,487	170,487
34 3400	SKILLED NURSING FACILITY	799,522	38,088	837,610		837,610
	ANCILLARY SRVC COST CNTRS					
37 3700	OPERATING ROOM	715,428	972,072	1,687,500		1,687,500
38 3800	RECOVERY ROOM					
39 3900	DELIVERY ROOM & LABOR ROOM	553,938	56,299	610,237	-487,648	122,589
40 4000	ANESTHESIOLOGY	821,634	22,326	843,960		843,960
41 4100	RADIOLOGY-DIAGNOSTIC	819,198	763,091	1,582,289		1,582,289
42 4200	RADIOLOGY-THERAPEUTIC					
44 4400	LABORATORY	904,303	1,236,989	2,141,292		2,141,292
48 4800	INTRAVENOUS THERAPY					
49 4900	RESPIRATORY THERAPY	475,373	40,547	515,920	-118,843	397,077
50 5000	PHYSICAL THERAPY	571,953	160,170	732,123		732,123
51 5100	OCCUPATIONAL THERAPY	262,631	35,986	298,617		298,617
52 5200	SPEECH PATHOLOGY	151,733	6,112	157,845		157,845
53 5300	ELECTROCARDIOLOGY		18,315	18,315	118,843	137,158
54 5400	ELECTROENCEPHALOGRAPHY					
55 5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		890,284	890,284	-243,732	646,552
55.30 5530	IMPL. DEV. CHARGED TO PATIENT				243,732	243,732
56 5600	DRUGS CHARGED TO PATIENTS	632,936	1,981,994	2,614,930		2,614,930
57 5700	RENAL DIALYSIS					
59 3550	OP PSYCH				188,299	188,299
59.97 3997	CARDIAC REHABILITATION					
	OUTPAT SERVICE COST CNTRS					
60 6000	CLINIC					
61 6100	EMERGENCY	1,343,364	387,270	1,730,634		1,730,634
62 6200	OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
65 6500	AMBULANCE SERVICES	829,288	64,846	894,134		894,134
66 6600	DURABLE MEDICAL EQUIP-RENTED	9,370	36,592	45,962		45,962
67 6700	DURABLE MEDICAL EQUIP-SOLD					
71 7100	HOME HEALTH AGENCY	622,872	65,171	688,043		688,043
	SPEC PURPOSE COST CENTERS					
92 9200	AMBULATORY SURGICAL CENTER (D.P.)					
93 9300	HOSPICE					
95	SUBTOTALS	15,656,633	24,598,002	40,254,635	13,100	40,267,735
	NONREIMBURS COST CENTERS					
96 9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
100 7950	TITLE XX	46,922	9,733	56,655		56,655
100.01 7951	OTHER NRCC	1,305,937	209,830	1,515,767		1,515,767
100.02 7952	PHYSICIAN OFFICES	1,359,152	393,749	1,752,901	-13,100	1,739,801
101	TOTAL	18,368,644	25,211,314	43,579,958	-0-	43,579,958

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
I 15-1330 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	-169,124	1,344,373
4 0400	NEW CAP REL COSTS-MVBLE EQUIP		
4.01 0401	NEW CAP REL COSTS-RENTAL	-11,772	2,357,923
5 0500	EMPLOYEE BENEFITS	-200,444	6,092,501
6 0600	ADMINISTRATIVE & GENERAL	-308,960	5,426,046
8 0800	OPERATION OF PLANT		1,026,809
8.01 0801	BIO-MEDICAL		98,758
8.02 0802	UTILITIES - HOSPITAL		519,515
8.03 0803	UTILITIES - OFFSITE BLDGS		82,688
9 0900	LAUNDRY & LINEN SERVICE		175,649
10 1000	HOUSEKEEPING		492,052
11 1100	DIETARY		233,004
12 1200	CAFETERIA	-389,455	513,592
14 1400	NURSING ADMINISTRATION		871,504
15 1500	CENTRAL SERVICES & SUPPLY		
16 1600	PHARMACY		
17 1700	MEDICAL RECORDS & LIBRARY	-22,889	528,447
	INPAT ROUTINE SRVC CNTRS		
25 2500	ADULTS & PEDIATRICS		1,702,496
26 2600	INTENSIVE CARE UNIT		539,486
31 3100	SUBPROVIDER	-66,667	932,748
33 3300	NURSERY		170,487
34 3400	SKILLED NURSING FACILITY		837,610
	ANCILLARY SRVC COST CNTRS		
37 3700	OPERATING ROOM		1,687,500
38 3800	RECOVERY ROOM		
39 3900	DELIVERY ROOM & LABOR ROOM		122,589
40 4000	ANESTHESIOLOGY	-843,960	
41 4100	RADIOLOGY-DIAGNOSTIC		1,582,289
42 4200	RADIOLOGY-THERAPEUTIC		
44 4400	LABORATORY	-58,538	2,082,754
48 4800	INTRAVENOUS THERAPY		
49 4900	RESPIRATORY THERAPY	-83,922	313,155
50 5000	PHYSICAL THERAPY		732,123
51 5100	OCCUPATIONAL THERAPY		298,617
52 5200	SPEECH PATHOLOGY		157,845
53 5300	ELECTROCARDIOLOGY		137,158
54 5400	ELECTROENCEPHALOGRAPHY		
55 5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		646,552
55.30 5530	IMPL. DEV. CHARGED TO PATIENT		243,732
56 5600	DRUGS CHARGED TO PATIENTS		2,614,930
57 5700	RENAL DIALYSIS		
59 3550	OP PSYCH		188,299
59.97 3997	CARDIAC REHABILITATION		
	OUTPAT SERVICE COST CNTRS		
60 6000	CLINIC		
61 6100	EMERGENCY	-920,006	810,628
62 6200	OBSERVATION BEDS (NON-DISTINCT PART)		
	OTHER REIMBURS COST CNTRS		
65 6500	AMBULANCE SERVICES		894,134
66 6600	DURABLE MEDICAL EQUIP-RENTED		45,962
67 6700	DURABLE MEDICAL EQUIP-SOLD		
71 7100	HOME HEALTH AGENCY		688,043
	SPEC PURPOSE COST CENTERS		
92 9200	AMBULATORY SURGICAL CENTER (D.P.)		
93 9300	HOSPICE		
95	SUBTOTALS	-3,075,737	37,191,998
	NONREIMBURS COST CENTERS		
96 9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
100 7950	TITLE XX		56,655
100.01 7951	OTHER NRCC		1,515,767
100.02 7952	PHYSICIAN OFFICES		1,739,801
101	TOTAL	-3,075,737	40,504,221

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
4.01	NEW CAP REL COSTS-RENTAL	0401	NEW CAP REL COSTS-MVBLE EQUIP
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
8.01	BIO-MEDICAL	0801	OPERATION OF PLANT
8.02	UTILITIES - HOSPITAL	0802	OPERATION OF PLANT
8.03	UTILITIES - OFFSITE BLDGS	0803	OPERATION OF PLANT
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
31	SUBPROVIDER	3100	
33	NURSERY	3300	
34	SKILLED NURSING FACILITY	3400	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
38	RECOVERY ROOM	3800	
39	DELIVERY ROOM & LABOR ROOM	3900	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
42	RADIOLOGY-THERAPEUTIC	4200	
44	LABORATORY	4400	
48	INTRAVENOUS THERAPY	4800	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
54	ELECTROENCEPHALOGRAPHY	5400	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
55.30	IMPL. DEV. CHARGED TO PATIENT	5530	IMPL. DEV. CHARGED TO PATIENT
56	DRUGS CHARGED TO PATIENTS	5600	
57	RENAL DIALYSIS	5700	
59	OP PSYCH	3550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES
59.97	CARDIAC REHABILITATION	3997	CARDIAC REHABILITATION
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
66	DURABLE MEDICAL EQUIP-RENTED	6600	
67	DURABLE MEDICAL EQUIP-SOLD	6700	
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
92	AMBULATORY SURGICAL CENTER (D.P.)	9200	
93	HOSPICE	9300	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
100	TITLE XX	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	OTHER NRCC	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	PHYSICIAN OFFICES	7952	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO: 151330	PERIOD: FROM 1/ 1/2010 TO 12/31/2010	PREPARED 5/27/2011 WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1)	COST CENTER	LINE NO	SALARY	OTHER
	1	2	3	4	5
1 OB, NURSERY AND L&D	A	ADULTS & PEDIATRICS	25	287,901	29,260
2		NURSERY	33	154,758	15,729
3 PROPERTY INSURANCE	B	NEW CAP REL COSTS-BLDG & FIXT	3		75,760
4 CAFETERIA	C	CAFETERIA	12	461,459	441,588
5 EKG SALARIES	D	ELECTROCARDIOLOGY	53	118,843	
6 O/P PSYCH	E	OP PSYCH	59	153,590	25,495
7 HOSPITAL USE OF SWISS CITY	F	ADMINISTRATIVE & GENERAL	6		3,886
8		OP PSYCH	59		9,214
9		UTILITIES - HOSPITAL	8.02		5,124
10 IMPLANTABLE DEVICES	G	IMPL. DEV. CHARGED TO PATIENT	55.30		243,732
36 TOTAL RECLASSIFICATIONS				1,176,551	849,788

(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:  
151330

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

PREPARED 5/27/2011  
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE		SALARY	OTHER	A-7 REF 10
			LINE NO				
1 OB, NURSERY AND L&D	A	6	39		442,659	44,989	
2							
3 PROPERTY INSURANCE	B		6			75,760	9
4 CAFETERIA	C		11		461,459	441,588	
5 EKG SALARIES	D		49		118,843		
6 O/P PSYCH	E		31		153,590	25,495	
7 HOSPITAL USE OF SWISS CITY	F		100.02			13,100	
8			8.03			5,124	
9							
10 IMPLANTABLE DEVICES	G		55			243,732	
36 TOTAL RECLASSIFICATIONS					1,176,551	849,788	

(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

RECLASS CODE: A  
EXPLANATION : OB, NURSERY AND L&D

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADULTS & PEDIATRICS	25	317,161	DELIVERY ROOM & LABOR ROOM	39	487,648
2.00	NURSERY	33	170,487			0
TOTAL RECLASSIFICATIONS FOR CODE A			487,648			487,648

RECLASS CODE: B  
EXPLANATION : PROPERTY INSURANCE

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	75,760	ADMINISTRATIVE & GENERAL	6	75,760
TOTAL RECLASSIFICATIONS FOR CODE B			75,760			75,760

RECLASS CODE: C  
EXPLANATION : CAFETERIA

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	903,047	DIETARY	11	903,047
TOTAL RECLASSIFICATIONS FOR CODE C			903,047			903,047

RECLASS CODE: D  
EXPLANATION : EKG SALARIES

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ELECTROCARDIOLOGY	53	118,843	RESPIRATORY THERAPY	49	118,843
TOTAL RECLASSIFICATIONS FOR CODE D			118,843			118,843

RECLASS CODE: E  
EXPLANATION : O/P PSYCH

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OP PSYCH	59	179,085	SUBPROVIDER	31	179,085
TOTAL RECLASSIFICATIONS FOR CODE E			179,085			179,085

RECLASS CODE: F  
EXPLANATION : HOSPITAL USE OF SWISS CITY

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	3,886	PHYSICIAN OFFICES	100.02	13,100
2.00	OP PSYCH	59	9,214	UTILITIES - OFFSITE BLDGS	8.03	5,124
3.00	UTILITIES - HOSPITAL	8.02	5,124			0
TOTAL RECLASSIFICATIONS FOR CODE F			18,224			18,224

RECLASS CODE: G  
EXPLANATION : IMPLANTABLE DEVICES

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	IMPL. DEV. CHARGED TO PATIENT	55.30	243,732	MEDICAL SUPPLIES CHARGED TO PA	55	243,732
TOTAL RECLASSIFICATIONS FOR CODE G			243,732			243,732

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING	ACQUISITIONS		TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		BALANCES	PURCHASES	DONATION				
		1	2	3	4	5	6	7
1	LAND	358,667					358,667	
2	LAND IMPROVEMENTS	1,206,356					1,206,356	
3	BUILDINGS & FIXTURE	33,344,312					33,344,312	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT	4,278,072					4,278,072	
6	MOVABLE EQUIPMENT	17,451,379	229,850		229,850		17,681,229	
7	SUBTOTAL	56,638,786	229,850		229,850		56,868,636	
8	RECONCILING ITEMS							
9	TOTAL	56,638,786	229,850		229,850		56,868,636	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL	
		GROSS ASSETS	CAPITIALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES		OTHER CAPITAL RELATED COSTS
		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	34,909,335		34,909,335	.613859				
4	NEW CAP REL COSTS-MV	21,959,301		21,959,301	.386141				
4 01	NEW CAP REL COSTS-RE								
5	TOTAL	56,868,636		56,868,636	1.000000				

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	1,344,373						1,344,373
4	NEW CAP REL COSTS-MV							
4 01	NEW CAP REL COSTS-RE	2,357,923						2,357,923
5	TOTAL	3,702,296						3,702,296

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	1,437,737						1,437,737
4	NEW CAP REL COSTS-MV							
4 01	NEW CAP REL COSTS-RE	2,369,695						2,369,695
5	TOTAL	3,807,432						3,807,432

\* 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 5/27/2011  
 I 15-1330 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 WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST. A-7 REF. 5
			COST CENTER	LINE NO	
	1	2	3	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	B	-169,124	NEW CAP REL COSTS-BLDG &	3	9
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	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	A	-8,956	ADMINISTRATIVE & GENERAL	6	
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-1,045,211			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1	-288,050			
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-389,455	CAFETERIA	12	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHERS					
18 SALE OF MED AND SURG SUPPLIES					
19 SALE OF DRUGS TO OTHER THAN PATIENTS					
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-22,889	MEDICAL RECORDS & LIBRARY	17	
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			**COST CENTER DELETED**	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			NEW CAP REL COSTS-MVBLE E	4	
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34 PHYSICIANS' ASSISTANT					
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		OCCUPATIONAL THERAPY	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
37 IHA DUES	A	-1,096	ADMINISTRATIVE & GENERAL	6	
38 AHA DUES	A	-3,282	ADMINISTRATIVE & GENERAL	6	
39 ANESTHESIOLOGY	A	-843,960	ANESTHESIOLOGY	40	
40 RAD EQUIP INT EXP - UNNECESSARY BORRO	A	-11,772	NEW CAP REL COSTS-RENTAL	4.01	9
41 TRANSPORTATION	B	-2,420	ADMINISTRATIVE & GENERAL	6	
42 OB RENTALS	B	-789	ADMINISTRATIVE & GENERAL	6	
43 WORTHMAN FITNESS CENTER	B	-83,922	RESPIRATORY THERAPY	49	
44 MISC INCOME	B	-4,367	ADMINISTRATIVE & GENERAL	6	
45 ER PHYSICIAN BENEFITS	A	-200,444	EMPLOYEE BENEFITS	5	
46 OTHER ADJUSTMENTS (SPECIFY)					
47 OTHER ADJUSTMENTS (SPECIFY)					
48 OTHER ADJUSTMENTS (SPECIFY)					
49 OTHER ADJUSTMENTS (SPECIFY)					
50 TOTAL (SUM OF LINES 1 THRU 49)		-3,075,737			

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

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	6	ADMINISTRATIVE & GENERAL	AHN- CAPITAL	103,670		103,670
2	6	ADMINISTRATIVE & GENERAL	AHN- A&G	1,204,342	1,596,062	-391,720
3						
4						
5	TOTALS			1,308,012	1,596,062	-288,050

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

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

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

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
1	B	ADAMS HEALTH NETWORK	0.00	ADAMS HEALTH NETWORK	0.00	MANAGEMENT
2			0.00		0.00	
3			0.00		0.00	
4			0.00		0.00	
5			0.00		0.00	

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET A-8-2  
 I I TO 12/31/2010 I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1 31	BEHAVIORAL HEALTH	66,667	66,667					
2 44	LAB	60,000	58,538	1,462				
3 61	ER	1,130,923	920,006	210,917				
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	1,257,590	1,045,211	212,379				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I  
I 15-1330  
I

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

I PREPARED 5/27/2011  
I WORKSHEET A-8-2  
I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF COL 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COL 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
10	11	12	13	14	15	16	17	18
1	31 BEHAVIORAL HEALTH							66,667
2	44 LAB							58,538
3	61 ER							920,006
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL							1,045,211

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

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET A-8-4  
 I I TO 12/31/2010 I PARTS I - VII

PHYSICAL 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)	293
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	5.50
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED	469.25	1688.75		
10	AHSEA (SEE INSTRUCTIONS)	69.57	50.43		
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	34.79	34.79	25.22	
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)	32,646
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	85,164
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS )	117,810
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)	117,810

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)	117,810

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)	10,193
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	10,193
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	1,612
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	11,805
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)	

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

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET A-8-4  
 I I TO 12/31/2010 I PARTS I - VII

PHYSICAL THERAPY

- 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)
- 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
- 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	117,810
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	
59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)	
61 EQUIPMENT COST (SEE INSTRUCTIONS)	
62 SUPPLIES (SEE INSTRUCTIONS)	
63 TOTAL ALLOWANCE (SUM OF LINES 57-62)	117,810
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	84,402

PHYSICAL THERAPY

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)	84,402
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)	84,402
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 15-1330  
 I PERIOD: I FROM 1/ 1/2010 I TO 12/31/2010  
 I PREPARED 5/27/2011 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)	274
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	5.50
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9		348.50	1231.00		
10		65.96	47.81		
11	32.98	32.98	23.91		
12					
12.01					
13					
13.01					

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)	22,987
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	58,854
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS )	81,841
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)	81,841

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)	81,841

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)	9,037
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	9,037
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	1,507
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	10,544
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)	

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

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET A-8-4  
 I I TO 12/31/2010 I PARTS I - VII

OCCUPATIONAL THERAPY

- 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)
- 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
- 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	81,841
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	
59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)	
61 EQUIPMENT COST (SEE INSTRUCTIONS)	
62 SUPPLIES (SEE INSTRUCTIONS)	
63 TOTAL ALLOWANCE (SUM OF LINES 57-62)	81,841
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	50,053

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 - 50,053  
 (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 50,053  
 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)

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I NOT A CMS WORKSHEET  
 I I TO 12/31/2010 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR VALUE	NOT ENTERED
4.01	NEW CAP REL COSTS-RENTAL	7	SQUARE FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM. COST	NOT ENTERED
8	OPERATION OF PLANT	7	SQUARE FEET	ENTERED
8.01	BIO-MEDICAL	1	COST	ENTERED
8.02	UTILITIES - HOSPITAL	3	SQUARE FEET	ENTERED
8.03	UTILITIES - OFFSITE BLDGS	2	COSTS	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	ENTERED
10	HOUSEKEEPING	7	SQUARE FEET	ENTERED
11	DIETARY	10	MEALS SERVED	ENTERED
12	CAFETERIA	11	HOURS	ENTERED
14	NURSING ADMINISTRATION	13	DIRECT NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	ENTERED
16	PHARMACY	15	COSTED REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 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 & 3	NEW CAP REL C OSTS-MVBLE E 4	NEW CAP REL C OSTS-RENTAL 4.01	EMPLOYEE BENE FITS 5	SUBTOTAL 5a.00	ADMINISTRATIV E & GENERAL 6
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	1,344,373	1,344,373					
004 01 NEW CAP REL COSTS-MVBLE E							
004 01 NEW CAP REL COSTS-RENTAL	2,357,923			2,357,923			
005 EMPLOYEE BENEFITS	6,092,501				6,092,501		
006 ADMINISTRATIVE & GENERAL	5,426,046	149,293		225,490	267,861	6,068,690	6,068,690
008 OPERATION OF PLANT	1,026,809	188,701		285,011	132,027	1,632,548	287,709
008 01 BIO-MEDICAL	98,758	4,423		6,681	18,227	128,089	22,574
008 02 UTILITIES - HOSPITAL	519,515					519,515	91,556
008 03 UTILITIES - OFFSITE BLDGS	82,688					82,688	14,572
009 LAUNDRY & LINEN SERVICE	175,649	34,055		51,436	13,174	274,314	48,343
010 HOUSEKEEPING	492,052	7,339		11,085	141,333	651,809	114,870
011 DIETARY	233,004	40,279		60,836	41,815	375,934	66,252
012 CAFETERIA	513,592	37,314		56,358	92,170	699,434	123,263
014 NURSING ADMINISTRATION	871,504	2,466		3,725	257,161	1,134,856	199,999
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY		14,698		22,200		36,898	6,503
017 MEDICAL RECORDS & LIBRARY	528,447	31,403		47,430	154,271	761,551	134,210
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	1,702,496	198,986		300,545	530,675	2,732,702	481,592
026 INTENSIVE CARE UNIT	539,486	39,065		59,004	184,957	822,512	144,954
031 SUBPROVIDER	932,748	69,157		104,453	301,020	1,407,378	248,026
033 NURSERY	170,487	4,227		6,385	54,350	235,449	41,494
034 SKILLED NURSING FACILITY	837,610	107,341		162,127	280,787	1,387,865	244,588
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	1,687,500	109,230		164,979	251,253	2,212,962	389,997
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO	122,589				39,080	161,669	28,491
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	1,582,289	93,876		141,789	287,697	2,105,651	371,085
042 RADIOLOGY-THERAPEUTIC							
044 LABORATORY	2,082,754	36,893		55,722	317,585	2,492,954	439,341
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	313,155	13,426		20,279	125,211	472,071	83,194
050 PHYSICAL THERAPY	732,123	62,718		94,728	200,866	1,090,435	192,171
051 OCCUPATIONAL THERAPY	298,617	2,740		4,139	92,234	397,730	70,093
052 SPEECH PATHOLOGY	157,845	1,370		2,069	53,288	214,572	37,815
053 ELECTROCARDIOLOGY	137,158	1,174		1,774	41,737	181,843	32,047
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED	646,552					646,552	113,944
055 30 IMPL. DEV. CHARGED TO PAT	243,732					243,732	42,954
056 DRUGS CHARGED TO PATIENTS	2,614,930				222,283	2,837,213	500,022
057 RENAL DIALYSIS							
059 OP PSYCH	188,299				53,940	242,239	42,691
059 97 CARDIAC REHABILITATION							
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC							
061 EMERGENCY	810,628	48,342		73,015	471,780	1,403,765	247,390
062 OBSERVATION BEDS (NON-DIS							
062 OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES	894,134			63,896	291,240	1,249,270	220,163
066 DURABLE MEDICAL EQUIP-REN	45,962	10,256		15,490		71,708	12,637
067 DURABLE MEDICAL EQUIP-SOL					3,291	3,291	580
071 HOME HEALTH AGENCY	688,043			161,521	218,748	1,068,312	188,272
092 SPEC PURPOSE COST CENTERS							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	37,191,998	1,308,772		2,202,167	5,140,061	36,048,201	5,283,392
095 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP		11,273		17,027		28,300	4,987
100 TITLE XX	56,655				16,479	73,134	12,889
100 01 OTHER NRCC	1,515,767	24,328		92,851	458,636	2,091,582	368,606
100 02 PHYSICIAN OFFICES	1,739,801			45,878	477,325	2,263,004	398,816
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	40,504,221	1,344,373		2,357,923	6,092,501	40,504,221	6,068,690

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET B  
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	OPERATION OF PLANT	BIO-MEDICAL	UTILITIES - HOSPITAL	UTILITIES - OFFSITE BLDGS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
	8	8.01	8.02	8.03	9	10	11
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
004 01 NEW CAP REL COSTS-RENTAL							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
008 OPERATION OF PLANT	1,920,257						
008 01 BIO-MEDICAL	6,944	157,607					
008 02 UTILITIES - HOSPITAL			611,071				
008 03 UTILITIES - OFFSITE BLDGS				97,260			
009 LAUNDRY & LINEN SERVICE	53,464		20,769		396,890		
010 HOUSEKEEPING	11,522		4,476		71,207	853,884	
011 DIETARY	63,235		24,565		2,414	29,213	561,613
012 CAFETERIA	58,580		22,757		9,353	27,062	
014 NURSING ADMINISTRATION	3,872		1,504			1,789	
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY	23,075		8,964			10,660	
017 MEDICAL RECORDS & LIBRARY	49,300		19,152			22,776	
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	312,393	26,288	121,358		60,177	144,320	240,467
026 INTENSIVE CARE UNIT	61,330	637	23,825		14,638	28,333	31,949
031 SUBPROVIDER	108,571	63	42,177		14,272	50,157	101,964
033 NURSERY	6,637	160	2,578			3,066	
034 SKILLED NURSING FACILITY	168,519	905	65,465		45,742	77,852	187,233
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	171,484	37,563	66,617		51,187	79,221	
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO					7,426		
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	147,379	73,654	57,253		23,595	68,086	
042 RADIOLOGY-THERAPEUTIC							
044 LABORATORY	57,919	5,062	22,500		528	26,757	
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	21,078	4,777	8,188		9,573	9,738	
050 PHYSICAL THERAPY	98,463	3,836	38,250			45,487	
051 OCCUPATIONAL THERAPY	4,302		1,671		20,172	1,987	
052 SPEECH PATHOLOGY	2,151		836			994	
053 ELECTROCARDIOLOGY	1,844	2,848	716			852	
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED							
055 30 IMPL. DEV. CHARGED TO PAT							
056 DRUGS CHARGED TO PATIENTS							
057 RENAL DIALYSIS							
059 OP PSYCH					2,576		
059 97 CARDIAC REHABILITATION							
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC							
061 EMERGENCY	75,894	243	29,483		35,289	35,061	
062 OBSERVATION BEDS (NON-DIS							
065 OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES	66,415	1,052		4,558	26,424	30,682	
066 DURABLE MEDICAL EQUIP-REN	16,101		6,255			7,438	
067 DURABLE MEDICAL EQUIP-SOL							
071 HOME HEALTH AGENCY	167,889	92				77,561	
092 SPEC PURPOSE COST CENTERS							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	1,758,361	157,180	589,359	4,558	394,573	779,092	561,613
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP	17,698		6,875			8,176	
100 TITLE XX							
100 01 OTHER NRCC	96,511	427	14,837	13,590	907	44,586	
100 02 PHYSICIAN OFFICES	47,687			79,112	1,410	22,030	
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	1,920,257	157,607	611,071	97,260	396,890	853,884	561,613

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET B  
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	CAFETERIA 12	NURSING ADMIN ISTRATION 14	CENTRAL SERVI CES & SUPPLY 15	PHARMACY 16	MEDICAL RECOR DS & LIBRARY 17	SUBTOTAL 25	I&R COST POST STEP- DOWN ADJ 26
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
004 01 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
008 OPERATION OF PLANT							
008 01 BIO-MEDICAL							
008 02 UTILITIES - HOSPITAL							
008 03 UTILITIES - OFFSITE BLDGS							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING							
011 DIETARY							
012 CAFETERIA	940,449						
014 NURSING ADMINISTRATION	41,969	1,383,989					
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY				86,100			
017 MEDICAL RECORDS & LIBRARY	27,538				1,014,527		
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	120,108	403,490			223,929	4,866,824	
026 INTENSIVE CARE UNIT	34,484	115,845			98,650	1,377,157	
031 SUBPROVIDER	73,380	246,509			31,850	2,324,347	
033 NURSERY	9,770	32,820			9,865	341,839	
034 SKILLED NURSING FACILITY	69,912	234,859			5,340	2,488,280	
034 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	58,616	196,911			60,440	3,324,998	
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO	7,024	23,597				228,207	
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	57,808				31,091	2,935,602	
042 RADIOLOGY-THERAPEUTIC							
044 LABORATORY	75,075					3,120,136	
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	28,983					637,602	
050 PHYSICAL THERAPY	37,103					1,505,745	
051 OCCUPATIONAL THERAPY	7,647					503,602	
052 SPEECH PATHOLOGY	11,293					267,661	
053 ELECTROCARDIOLOGY	9,661				1	229,812	
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED						760,496	
055 30 IMPL. DEV. CHARGED TO PAT						286,686	
056 DRUGS CHARGED TO PATIENTS	31,348			86,100		3,454,683	
057 RENAL DIALYSIS							
059 OP PSYCH	13,149				5,709	306,364	
059 97 CARDIAC REHABILITATION							
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
061 EMERGENCY	38,686	129,958			327,214	2,322,983	
062 OBSERVATION BEDS (NON-DIS							
065 OTHER REIMBURS COST CNTRS							
066 AMBULANCE SERVICES	103,556					1,702,120	
066 DURABLE MEDICAL EQUIP-REN						114,139	
067 DURABLE MEDICAL EQUIP-SOL	1,249					5,120	
071 HOME HEALTH AGENCY						1,502,126	
092 SPEC PURPOSE COST CENTERS							
093 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	858,359	1,383,989		86,100	794,089	34,606,529	
096 NONREIMBURS COST CENTERS							
100 GIFT, FLOWER, COFFEE SHOP						66,036	
100 TITLE XX						86,023	
100 01 OTHER NRCC	57,734				58,541	2,747,321	
100 02 PHYSICIAN OFFICES	24,356				161,897	2,998,312	
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	940,449	1,383,989		86,100	1,014,527	40,504,221	

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: 15-1330 I PERIOD: FROM 1/ 1/2010 TO 12/31/2010 I PREPARED 5/27/2011 I WORKSHEET B PART I

COST CENTER DESCRIPTION		TOTAL
		27
003	GENERAL SERVICE COST CNTR	
004	NEW CAP REL COSTS-BLDG &	
004	NEW CAP REL COSTS-MVBLE E	
004	01 NEW CAP REL COSTS-RENTAL	
005	EMPLOYEE BENEFITS	
006	ADMINISTRATIVE & GENERAL	
008	OPERATION OF PLANT	
008	01 BIO-MEDICAL	
008	02 UTILITIES - HOSPITAL	
008	03 UTILITIES - OFFSITE BLDGS	
009	LAUNDRY & LINEN SERVICE	
010	HOUSEKEEPING	
011	DIETARY	
012	CAFETERIA	
014	NURSING ADMINISTRATION	
015	CENTRAL SERVICES & SUPPLY	
016	PHARMACY	
017	MEDICAL RECORDS & LIBRARY	
	INPAT ROUTINE SRVC CNTRS	
025	ADULTS & PEDIATRICS	4,866,824
026	INTENSIVE CARE UNIT	1,377,157
031	SUBPROVIDER	2,324,347
033	NURSERY	341,839
034	SKILLED NURSING FACILITY	2,488,280
	ANCILLARY SRVC COST CNTRS	
037	OPERATING ROOM	3,324,998
038	RECOVERY ROOM	
039	DELIVERY ROOM & LABOR ROO	228,207
040	ANESTHESIOLOGY	
041	RADIOLOGY-DIAGNOSTIC	2,935,602
042	RADIOLOGY-THERAPEUTIC	
044	LABORATORY	3,120,136
048	INTRAVENOUS THERAPY	
049	RESPIRATORY THERAPY	637,602
050	PHYSICAL THERAPY	1,505,745
051	OCCUPATIONAL THERAPY	503,602
052	SPEECH PATHOLOGY	267,661
053	ELECTROCARDIOLOGY	229,812
054	ELECTROENCEPHALOGRAPHY	
055	MEDICAL SUPPLIES CHARGED	760,496
055	30 IMPL. DEV. CHARGED TO PAT	286,686
056	DRUGS CHARGED TO PATIENTS	3,454,683
057	RENAL DIALYSIS	
059	OP PSYCH	306,364
059	97 CARDIAC REHABILITATION	
	OUTPAT SERVICE COST CNTRS	
060	CLINIC	
061	EMERGENCY	2,322,983
062	OBSERVATION BEDS (NON-DIS	
	OTHER REIMBURS COST CNTRS	
065	AMBULANCE SERVICES	1,702,120
066	DURABLE MEDICAL EQUIP-REN	114,139
067	DURABLE MEDICAL EQUIP-SOL	5,120
071	HOME HEALTH AGENCY	1,502,126
	SPEC PURPOSE COST CENTERS	
092	AMBULATORY SURGICAL CENTE	
093	HOSPICE	
095	SUBTOTALS	34,606,529
	NONREIMBURS COST CENTERS	
096	GIFT, FLOWER, COFFEE SHOP	66,036
100	TITLE XX	86,023
100	01 OTHER NRCC	2,747,321
100	02 PHYSICIAN OFFICES	2,998,312
101	CROSS FOOT ADJUSTMENT	
102	NEGATIVE COST CENTER	
103	TOTAL	40,504,221

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET B  
 I I TO 12/31/2010 I PART III

COST CENTER DESCRIPTION	DIR ASSIGNED NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	NEW CAP REL C OSTS-RENTAL	SUBTOTAL	EMPLOYEE BENE FITS	ADMINISTRATIV E & GENERAL
	0	3	4	4.01	4a	5	6
GENERAL SERVICE COST CNTR							
003 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
004 01 NEW CAP REL COSTS-RENTAL							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL		149,293		225,490	374,783		374,783
008 OPERATION OF PLANT		188,701		285,011	473,712		17,769
008 01 BIO-MEDICAL		4,423		6,681	11,104		1,394
008 02 UTILITIES - HOSPITAL							5,654
008 03 UTILITIES - OFFSITE BLDGS							900
009 LAUNDRY & LINEN SERVICE		34,055		51,436	85,491		2,986
010 HOUSEKEEPING		7,339		11,085	18,424		7,094
011 DIETARY		40,279		60,836	101,115		4,092
012 CAFETERIA		37,314		56,358	93,672		7,613
014 NURSING ADMINISTRATION		2,466		3,725	6,191		12,352
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY		14,698		22,200	36,898		402
017 MEDICAL RECORDS & LIBRARY		31,403		47,430	78,833		8,289
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS		198,986		300,545	499,531		29,743
026 INTENSIVE CARE UNIT		39,065		59,004	98,069		8,952
031 SUBPROVIDER		69,157		104,453	173,610		15,318
033 NURSERY		4,227		6,385	10,612		2,563
034 SKILLED NURSING FACILITY		107,341		162,127	269,468		15,106
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		109,230		164,979	274,209		24,086
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO							1,760
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC		93,876		141,789	235,665		22,918
042 RADIOLOGY-THERAPEUTIC							
044 LABORATORY		36,893		55,722	92,615		27,133
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY		13,426		20,279	33,705		5,138
050 PHYSICAL THERAPY		62,718		94,728	157,446		11,868
051 OCCUPATIONAL THERAPY		2,740		4,139	6,879		4,329
052 SPEECH PATHOLOGY		1,370		2,069	3,439		2,335
053 ELECTROCARDIOLOGY		1,174		1,774	2,948		1,979
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED							7,037
055 30 IMPL. DEV. CHARGED TO PAT							2,653
056 DRUGS CHARGED TO PATIENTS							30,863
057 RENAL DIALYSIS							
059 OP PSYCH							2,637
059 97 CARDIAC REHABILITATION							
OUTPAT SERVICE COST CNTRS							
060 CLINIC							
061 EMERGENCY		48,342		73,015	121,357		15,279
062 OBSERVATION BEDS (NON-DIS							
OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES				63,896	63,896		13,597
066 DURABLE MEDICAL EQUIP-REN		10,256		15,490	25,746		780
067 DURABLE MEDICAL EQUIP-SOL							36
071 HOME HEALTH AGENCY				161,521	161,521		11,628
SPEC PURPOSE COST CENTERS							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS		1,308,772		2,202,167	3,510,939		326,283
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP		11,273		17,027	28,300		308
100 TITLE XX							796
100 01 OTHER NRCC		24,328		92,851	117,179		22,765
100 02 PHYSICIAN OFFICES				45,878	45,878		24,631
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		1,344,373		2,357,923	3,702,296		374,783

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET B  
 I I TO 12/31/2010 I PART III

COST CENTER DESCRIPTION	OPERATION OF PLANT	BIO-MEDICAL	UTILITIES - HOSPITAL	UTILITIES - OFFSITE BLDGS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
	8	8.01	8.02	8.03	9	10	11
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
004 01 NEW CAP REL COSTS-RENTAL							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
008 OPERATION OF PLANT	491,481						
008 01 BIO-MEDICAL	1,777	14,275					
008 02 UTILITIES - HOSPITAL			5,654				
008 03 UTILITIES - OFFSITE BLDGS				900			
009 LAUNDRY & LINEN SERVICE	13,684		192		102,353		
010 HOUSEKEEPING	2,949		41		18,362	46,870	
011 DIETARY	16,185		227		623	1,604	123,846
012 CAFETERIA	14,993		211		2,412	1,485	
014 NURSING ADMINISTRATION	991		14			98	
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY	5,906		83			585	
017 MEDICAL RECORDS & LIBRARY	12,618		177			1,250	
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	79,956	2,381	1,123		15,519	7,923	53,028
026 INTENSIVE CARE UNIT	15,697	58	220		3,775	1,555	7,045
031 SUBPROVIDER	27,788	6	390		3,681	2,753	22,485
033 NURSERY	1,699	14	24			168	
034 SKILLED NURSING FACILITY	43,132	82	606		11,796	4,273	41,288
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	43,890	3,402	616		13,201	4,348	
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO					1,915		
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	37,721	6,671	530		6,085	3,737	
042 RADIOLOGY-THERAPEUTIC							
044 LABORATORY	14,824	459	208		136	1,469	
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	5,395	433	76		2,469	535	
050 PHYSICAL THERAPY	25,201	347	354			2,497	
051 OCCUPATIONAL THERAPY	1,101		15		5,202	109	
052 SPEECH PATHOLOGY	550		8			55	
053 ELECTROCARDIOLOGY	472	258	7			47	
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED							
055 30 IMPL. DEV. CHARGED TO PAT							
056 DRUGS CHARGED TO PATIENTS							
057 RENAL DIALYSIS							
059 OP PSYCH					664		
059 97 CARDIAC REHABILITATION							
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC							
061 EMERGENCY	19,425	22	273		9,100	1,925	
062 OBSERVATION BEDS (NON-DIS							
062 OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES	16,999	95		42	6,815	1,684	
066 DURABLE MEDICAL EQUIP-REN	4,121		58			408	
067 DURABLE MEDICAL EQUIP-SOL							
071 HOME HEALTH AGENCY	42,970	8				4,257	
092 SPEC PURPOSE COST CENTERS							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	450,044	14,236	5,453	42	101,755	42,765	123,846
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP	4,530		64			449	
100 TITLE XX							
100 01 OTHER NRCC	24,702	39	137	126	234	2,447	
100 02 PHYSICIAN OFFICES	12,205			732	364	1,209	
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	491,481	14,275	5,654	900	102,353	46,870	123,846

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	CAFETERIA 12	NURSING ADMIN ISTRATION 14	CENTRAL SERVI CES & SUPPLY 15	PHARMACY 16	MEDICAL RECOR DS & LIBRARY 17	SUBTOTAL 25	POST STEPDOWN ADJUSTMENT 26
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
004 01 NEW CAP REL COSTS-RENTAL							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
008 OPERATION OF PLANT							
008 01 BIO-MEDICAL							
008 02 UTILITIES - HOSPITAL							
008 03 UTILITIES - OFFSITE BLDGS							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING							
011 DIETARY							
012 CAFETERIA	120,386						
014 NURSING ADMINISTRATION	5,372	25,018					
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY				43,874			
017 MEDICAL RECORDS & LIBRARY	3,525				104,692		
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	15,377	7,294			23,108	734,983	
026 INTENSIVE CARE UNIT	4,414	2,094			10,180	152,059	
031 SUBPROVIDER	9,393	4,456			3,287	263,167	
033 NURSERY	1,251	593			1,018	17,942	
034 SKILLED NURSING FACILITY	8,949	4,245			551	399,496	
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	7,503	3,560			6,237	381,052	
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO	899	427				5,001	
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	7,400				3,208	323,935	
042 RADIOLOGY-THERAPEUTIC							
044 LABORATORY	9,610					146,454	
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	3,710					51,461	
050 PHYSICAL THERAPY	4,749					202,462	
051 OCCUPATIONAL THERAPY	979					18,614	
052 SPEECH PATHOLOGY	1,446					7,833	
053 ELECTROCARDIOLOGY	1,237					6,948	
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED						7,037	
055 30 IMPL. DEV. CHARGED TO PAT						2,653	
056 DRUGS CHARGED TO PATIENTS	4,013			43,874		78,750	
057 RENAL DIALYSIS							
059 OP PSYCH	1,683				589	5,573	
059 97 CARDIAC REHABILITATION							
OUTPAT SERVICE COST CNTRS							
060 CLINIC							
061 EMERGENCY	4,952	2,349			33,766	208,448	
062 OBSERVATION BEDS (NON-DIS							
OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES	13,256					116,384	
066 DURABLE MEDICAL EQUIP-REN						31,113	
067 DURABLE MEDICAL EQUIP-SOL	160					196	
071 HOME HEALTH AGENCY						220,384	
SPEC PURPOSE COST CENTERS							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	109,878	25,018		43,874	81,944	3,381,945	
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP						33,651	
100 TITLE XX						796	
100 01 OTHER NRCC	7,390				6,041	181,060	
100 02 PHYSICIAN OFFICES	3,118				16,707	104,844	
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	120,386	25,018		43,874	104,692	3,702,296	

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET B  
 I I TO 12/31/2010 I PART III

COST CENTER DESCRIPTION		TOTAL
		27
003	GENERAL SERVICE COST CNTR	
004	NEW CAP REL COSTS-BLDG &	
004	NEW CAP REL COSTS-MVBLE E	
004	01 NEW CAP REL COSTS-RENTAL	
005	EMPLOYEE BENEFITS	
006	ADMINISTRATIVE & GENERAL	
008	OPERATION OF PLANT	
008	01 BIO-MEDICAL	
008	02 UTILITIES - HOSPITAL	
008	03 UTILITIES - OFFSITE BLDGS	
009	LAUNDRY & LINEN SERVICE	
010	HOUSEKEEPING	
011	DIETARY	
012	CAFETERIA	
014	NURSING ADMINISTRATION	
015	CENTRAL SERVICES & SUPPLY	
016	PHARMACY	
017	MEDICAL RECORDS & LIBRARY	
	INPAT ROUTINE SRVC CNTRS	
025	ADULTS & PEDIATRICS	734,983
026	INTENSIVE CARE UNIT	152,059
031	SUBPROVIDER	263,167
033	NURSERY	17,942
034	SKILLED NURSING FACILITY	399,496
	ANCILLARY SRVC COST CNTRS	
037	OPERATING ROOM	381,052
038	RECOVERY ROOM	
039	DELIVERY ROOM & LABOR ROO	5,001
040	ANESTHESIOLOGY	
041	RADIOLOGY-DIAGNOSTIC	323,935
042	RADIOLOGY-THERAPEUTIC	
044	LABORATORY	146,454
048	INTRAVENOUS THERAPY	
049	RESPIRATORY THERAPY	51,461
050	PHYSICAL THERAPY	202,462
051	OCCUPATIONAL THERAPY	18,614
052	SPEECH PATHOLOGY	7,833
053	ELECTROCARDIOLOGY	6,948
054	ELECTROENCEPHALOGRAPHY	
055	MEDICAL SUPPLIES CHARGED	7,037
055	30 IMPL. DEV. CHARGED TO PAT	2,653
056	DRUGS CHARGED TO PATIENTS	78,750
057	RENAL DIALYSIS	
059	OP PSYCH	5,573
059	97 CARDIAC REHABILITATION	
	OUTPAT SERVICE COST CNTRS	
060	CLINIC	
061	EMERGENCY	208,448
062	OBSERVATION BEDS (NON-DIS	
	OTHER REIMBURS COST CNTRS	
065	AMBULANCE SERVICES	116,384
066	DURABLE MEDICAL EQUIP-REN	31,113
067	DURABLE MEDICAL EQUIP-SOL	196
071	HOME HEALTH AGENCY	220,384
	SPEC PURPOSE COST CENTERS	
092	AMBULATORY SURGICAL CENTE	
093	HOSPICE	
095	SUBTOTALS	3,381,945
	NONREIMBURS COST CENTERS	
096	GIFT, FLOWER, COFFEE SHOP	33,651
100	TITLE XX	796
100	01 OTHER NRCC	181,060
100	02 PHYSICIAN OFFICES	104,844
101	CROSS FOOT ADJUSTMENTS	
102	NEGATIVE COST CENTER	
103	TOTAL	3,702,296

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/1/2010 I WORKSHEET B-1  
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	NEW CAP REL C OSTS-BLDG & (SQUARE FEET)	NEW CAP REL C OSTS-MVBLE E (DOLLAR VALUE)	NEW CAP REL C OSTS-RENTAL (SQUARE FEET)	EMPLOYEE BENE FITS (GROSS SALARIES)	S RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)
	3	4	4.01	5	6a.00	6
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	137,379					
004 01 NEW CAP REL COSTS-MVB						
005 EMPLOYEE BENEFITS			159,530	17,347,999		
006 ADMINISTRATIVE & GENE	15,256		15,256	762,716	-6,068,690	34,435,531
008 OPERATION OF PLANT	19,283		19,283	375,939		1,632,548
008 01 BIO-MEDICAL	452		452	51,901		128,089
008 02 UTILITIES - HOSPITAL						519,515
008 03 UTILITIES - OFFSITE B						82,688
009 LAUNDRY & LINEN SERVI	3,480		3,480	37,511		274,314
010 HOUSEKEEPING	750		750	402,437		651,809
011 DIETARY	4,116		4,116	119,065		375,934
012 CAFETERIA	3,813		3,813	262,447		699,434
014 NURSING ADMINISTRATIO	252		252	732,250		1,134,856
015 CENTRAL SERVICES & SU						
016 PHARMACY	1,502		1,502			36,898
017 MEDICAL RECORDS & LIB	3,209		3,209	439,278		761,551
025 INPAT ROUTINE SRVC CN						
026 ADULTS & PEDIATRICS	20,334		20,334	1,511,058		2,732,702
031 INTENSIVE CARE UNIT	3,992		3,992	526,653		822,512
033 SUBPROVIDER	7,067		7,067	857,135		1,407,378
034 NURSERY	432		432	154,758		235,449
034 SKILLED NURSING FACIL	10,969		10,969	799,522		1,387,865
037 ANCILLARY SRVC COST C						
038 OPERATING ROOM	11,162		11,162	715,428		2,212,962
039 RECOVERY ROOM						
040 DELIVERY ROOM & LABOR				111,279		161,669
041 ANESTHESIOLOGY						
041 RADIOLOGY-DIAGNOSTIC	9,593		9,593	819,198		2,105,651
042 RADIOLOGY-THERAPEUTIC						
044 LABORATORY	3,770		3,770	904,303		2,492,954
048 INTRAVENOUS THERAPY						
049 RESPIRATORY THERAPY	1,372		1,372	356,530		472,071
050 PHYSICAL THERAPY	6,409		6,409	571,953		1,090,435
051 OCCUPATIONAL THERAPY	280		280	262,631		397,730
052 SPEECH PATHOLOGY	140		140	151,733		214,572
053 ELECTROCARDIOLOGY	120		120	118,843		181,843
054 ELECTROENCEPHALOGRAPH						
055 MEDICAL SUPPLIES CHAR						646,552
055 30 IMPL. DEV. CHARGED TO						243,732
056 DRUGS CHARGED TO PATI				632,936		2,837,213
057 RENAL DIALYSIS						
059 OP PSYCH				153,590		242,239
059 97 CARDIAC REHABILITATIO						
060 OUTPAT SERVICE COST C						
061 CLINIC						
061 EMERGENCY	4,940		4,940	1,343,364		1,403,765
062 OBSERVATION BEDS (NON						
062 OTHER REIMBURS COST C						
065 AMBULANCE SERVICES				829,288		1,249,270
066 DURABLE MEDICAL EQUIP	1,048		1,048			71,708
067 DURABLE MEDICAL EQUIP				9,370		3,291
071 HOME HEALTH AGENCY			10,928	622,872		1,068,312
092 SPEC PURPOSE COST CEN						
093 AMBULATORY SURGICAL C						
093 HOSPICE						
095 SUBTOTALS	133,741		148,992	14,635,988	-6,068,690	29,979,511
096 NONREIMBURS COST CENT						
100 GIFT, FLOWER, COFFEE	1,152		1,152			28,300
100 TITLE XX				46,922		73,134
100 01 OTHER NRCC	2,486		6,282	1,305,937		2,091,582
100 02 PHYSICIAN OFFICES			3,104	1,359,152		2,263,004
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	1,344,373		2,357,923	6,092,501		6,068,690
104 (WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	9.785870		14.780436			
105 (WRKSHT B, PT I)				.351193		.176233
105 COST TO BE ALLOCATED						
106 (WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
107 (WRKSHT B, PT II)						
107 COST TO BE ALLOCATED						374,783
108 (WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER						.010884
108 (WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET B-1  
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	OPERATION OF PLANT (SQUARE FEET)	BIO-MEDICAL (COST)	UTILITIES - HOSPITAL (SQUARE FEET)	UTILITIES - OFFSITE BLDGS (COSTS)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	S
	8	8.01	8.02	8.03	9	10	11	
GENERAL SERVICE COST								
003 NEW CAP REL COSTS-BLD								
004 NEW CAP REL COSTS-MVB								
004 01 NEW CAP REL COSTS-REN								
005 EMPLOYEE BENEFITS								
006 ADMINISTRATIVE & GENE								
008 OPERATION OF PLANT	124,991							
008 01 BIO-MEDICAL	452	10,750,361						
008 02 UTILITIES - HOSPITAL			102,388					
008 03 UTILITIES - OFFSITE B				87,812				
009 LAUNDRY & LINEN SERVI	3,480		3,480		252,529			
010 HOUSEKEEPING	750		750		45,306	120,309		
011 DIETARY	4,116		4,116		1,536	4,116	38,550	
012 CAFETERIA	3,813		3,813		5,951	3,813		
014 NURSING ADMINISTRATIO	252		252			252		
015 CENTRAL SERVICES & SU								
016 PHARMACY	1,502		1,502			1,502		
017 MEDICAL RECORDS & LIB	3,209		3,209			3,209		
INPAT ROUTINE SRVC CN								
025 ADULTS & PEDIATRICS	20,334	1,793,090	20,334		38,289	20,334	16,506	
026 INTENSIVE CARE UNIT	3,992	43,469	3,992		9,314	3,992	2,193	
031 SUBPROVIDER	7,067	4,306	7,067		9,081	7,067	6,999	
033 NURSERY	432	10,909	432			432		
034 SKILLED NURSING FACIL	10,969	61,732	10,969		29,104	10,969	12,852	
ANCILLARY SRVC COST C								
037 OPERATING ROOM	11,162	2,562,096	11,162		32,569	11,162		
038 RECOVERY ROOM								
039 DELIVERY ROOM & LABOR					4,725			
040 ANESTHESIOLOGY								
041 RADIOLOGY-DIAGNOSTIC	9,593	5,024,043	9,593		15,013	9,593		
042 RADIOLOGY-THERAPEUTIC								
044 LABORATORY	3,770	345,272	3,770		336	3,770		
048 INTRAVENOUS THERAPY								
049 RESPIRATORY THERAPY	1,372	325,862	1,372		6,091	1,372		
050 PHYSICAL THERAPY	6,409	261,650	6,409			6,409		
051 OCCUPATIONAL THERAPY	280		280		12,835	280		
052 SPEECH PATHOLOGY	140		140			140		
053 ELECTROCARDIOLOGY	120	194,228	120			120		
054 ELECTROENCEPHALOGRAPH								
055 MEDICAL SUPPLIES CHAR								
055 30 IMPL. DEV. CHARGED TO								
056 DRUGS CHARGED TO PATI								
057 RENAL DIALYSIS								
059 OP PSYCH					1,639			
059 97 CARDIAC REHABILITATIO								
OUTPAT SERVICE COST C								
060 CLINIC								
061 EMERGENCY	4,940	16,600	4,940		22,453	4,940		
062 OBSERVATION BEDS (NON								
OTHER REIMBURS COST C								
065 AMBULANCE SERVICES	4,323	71,747		4,115	16,813	4,323		
066 DURABLE MEDICAL EQUIP	1,048		1,048			1,048		
067 DURABLE MEDICAL EQUIP								
071 HOME HEALTH AGENCY	10,928	6,261				10,928		
SPEC PURPOSE COST CEN								
092 AMBULATORY SURGICAL C								
093 HOSPICE								
095 SUBTOTALS	114,453	10,721,265	98,750	4,115	251,055	109,771	38,550	
NONREIMBURS COST CENT								
096 GIFT, FLOWER, COFFEE	1,152		1,152			1,152		
100 TITLE XX								
100 01 OTHER NRCC	6,282	29,096	2,486	12,270	577	6,282		
100 02 PHYSICIAN OFFICES	3,104			71,427	897	3,104		
CROSS FOOT ADJUSTMENT								
102 NEGATIVE COST CENTER								
103 COST TO BE ALLOCATED	1,920,257	157,607	611,071	97,260	396,890	853,884	561,613	
(WRKSHT B, PART I)								
104 UNIT COST MULTIPLIER		.014661		1.107593		7.097424		
(WRKSHT B, PT I)	15.363162		5.968190		1.571661		14.568431	
105 COST TO BE ALLOCATED								
(WRKSHT B, PART II)								
106 UNIT COST MULTIPLIER								
(WRKSHT B, PT II)								
107 COST TO BE ALLOCATED	491,481	14,275	5,654	900	102,353	46,870	123,846	
(WRKSHT B, PART III)								
108 UNIT COST MULTIPLIER		.001328		.010249		.389580		
(WRKSHT B, PT III)	3.932131		.055221		.405312		3.212607	

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET B-1  
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT )SING HRS	CENTRAL SERVICES & SUPPLY NR(COSTED )EQUIS.	PHARMACY R(COSTED )EQUIS.	MEDICAL RECORDS & LIBRARY R(TIME )SPENT
GENERAL SERVICE COST	12	14	15	16	17
003 NEW CAP REL COSTS-BLD					
004 NEW CAP REL COSTS-MVB					
004 01 NEW CAP REL COSTS-REN					
005 EMPLOYEE BENEFITS					
006 ADMINISTRATIVE & GENE					
008 OPERATION OF PLANT					
008 01 BIO-MEDICAL					
008 02 UTILITIES - HOSPITAL					
008 03 UTILITIES - OFFSITE B					
009 LAUNDRY & LINEN SERVI					
010 HOUSEKEEPING					
011 DIETARY					
012 CAFETERIA	519,337				
014 NURSING ADMINISTRATIO	23,176	227,505			
015 CENTRAL SERVICES & SU			890,284		
016 PHARMACY				100	
017 MEDICAL RECORDS & LIB	15,207				921,781
INPAT ROUTINE SRVC CN					
025 ADULTS & PEDIATRICS	66,327	66,327			203,458
026 INTENSIVE CARE UNIT	19,043	19,043			89,632
031 SUBPROVIDER	40,522	40,522			28,938
033 NURSERY	5,395	5,395			8,963
034 SKILLED NURSING FACIL	38,607	38,607			4,852
ANCILLARY SRVC COST C					
037 OPERATING ROOM	32,369	32,369			54,915
038 RECOVERY ROOM					
039 DELIVERY ROOM & LABOR	3,879	3,879			
040 ANESTHESIOLOGY					
041 RADIOLOGY-DIAGNOSTIC	31,923				28,249
042 RADIOLOGY-THERAPEUTIC					
044 LABORATORY	41,458				
048 INTRAVENOUS THERAPY					
049 RESPIRATORY THERAPY	16,005				
050 PHYSICAL THERAPY	20,489				
051 OCCUPATIONAL THERAPY	4,223				
052 SPEECH PATHOLOGY	6,236				
053 ELECTROCARDIOLOGY	5,335				1
054 ELECTROENCEPHALOGRAPH					
055 MEDICAL SUPPLIES CHAR			646,552		
055 30 IMPL. DEV. CHARGED TO			243,732		
056 DRUGS CHARGED TO PATI	17,311			100	
057 RENAL DIALYSIS					
059 OP PSYCH	7,261				5,187
059 97 CARDIAC REHABILITATIO					
OUTPAT SERVICE COST C					
060 CLINIC					
061 EMERGENCY	21,363	21,363			297,300
062 OBSERVATION BEDS (NON					
OTHER REIMBURS COST C					
065 AMBULANCE SERVICES	57,186				
066 DURABLE MEDICAL EQUIP					
067 DURABLE MEDICAL EQUIP	690				
071 HOME HEALTH AGENCY					
SPEC PURPOSE COST CEN					
092 AMBULATORY SURGICAL C					
093 HOSPICE					
095 SUBTOTALS	474,005	227,505	890,284	100	721,495
NONREIMBURS COST CENT					
096 GIFT, FLOWER, COFFEE					
100 TITLE XX					
100 01 OTHER NRCC	31,882				53,189
100 02 PHYSICIAN OFFICES	13,450				147,097
101 CROSS FOOT ADJUSTMENT					
102 NEGATIVE COST CENTER					
103 COST TO BE ALLOCATED	940,449	1,383,989		86,100	1,014,527
(PER WRKSHT B, PART					
UNIT COST MULTIPLIER		6.083334		861.000000	
(WRKSHT B, PT I)	1.810865				1.100616
105 COST TO BE ALLOCATED					
(PER WRKSHT B, PART					
UNIT COST MULTIPLIER					
(WRKSHT B, PT II)					
107 COST TO BE ALLOCATED	120,386	25,018		43,874	104,692
(PER WRKSHT B, PART					
UNIT COST MULTIPLIER		.109967		438.740000	
(WRKSHT B, PT III)	.231807				.113576

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: 15-1330 I PERIOD: FROM 1/ 1/2010 TO 12/31/2010 I PREPARED 5/27/2011 I WORKSHEET C I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	4,866,824		4,866,824		4,866,824
26	INTENSIVE CARE UNIT	1,377,157		1,377,157		1,377,157
31	SUBPROVIDER	2,324,347		2,324,347		2,324,347
33	NURSERY	341,839		341,839		341,839
34	SKILLED NURSING FACILITY	2,488,280		2,488,280		2,488,280
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	3,324,998		3,324,998		3,324,998
38	RECOVERY ROOM					
39	DELIVERY ROOM & LABOR ROO	228,207		228,207		228,207
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	2,935,602		2,935,602		2,935,602
42	RADIOLOGY-THERAPEUTIC					
44	LABORATORY	3,120,136		3,120,136		3,120,136
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	637,602		637,602		637,602
50	PHYSICAL THERAPY	1,505,745		1,505,745		1,505,745
51	OCCUPATIONAL THERAPY	503,602		503,602		503,602
52	SPEECH PATHOLOGY	267,661		267,661		267,661
53	ELECTROCARDIOLOGY	229,812		229,812		229,812
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	760,496		760,496		760,496
55	30 IMPL. DEV. CHARGED TO PAT	286,686		286,686		286,686
56	DRUGS CHARGED TO PATIENTS	3,454,683		3,454,683		3,454,683
57	RENAL DIALYSIS					
59	OP PSYCH	306,364		306,364		306,364
59	97 CARDIAC REHABILITATION					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	2,322,983		2,322,983		2,322,983
62	OBSERVATION BEDS (NON-DIS	673,877		673,877		673,877
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	1,702,120		1,702,120		1,702,120
66	DURABLE MEDICAL EQUIP-REN	114,139		114,139		114,139
67	DURABLE MEDICAL EQUIP-SOL	5,120		5,120		5,120
101	SUBTOTAL	33,778,280		33,778,280		33,778,280
102	LESS OBSERVATION BEDS	673,877		673,877		673,877
103	TOTAL	33,104,403		33,104,403		33,104,403

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 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	6,171,685		6,171,685			
26	INTENSIVE CARE UNIT	2,200,608		2,200,608			
31	SUBPROVIDER	3,252,776		3,252,776			
33	NURSERY	242,143		242,143			
34	SKILLED NURSING FACILITY	1,896,045		1,896,045			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,281,032	4,685,776	5,966,808	.557249	.557249	.557249
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO	116,180	57,934	174,114	1.310676	1.310676	1.310676
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	1,876,411	16,594,943	18,471,354	.158927	.158927	.158927
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY	2,776,177	12,398,081	15,174,258	.205620	.205620	.205620
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	2,961,744	395,547	3,357,291	.189916	.189916	.189916
50	PHYSICAL THERAPY	748,112	1,235,228	1,983,340	.759197	.759197	.759197
51	OCCUPATIONAL THERAPY	377,207	581,001	958,208	.525566	.525566	.525566
52	SPEECH PATHOLOGY	190,510	437,505	628,015	.426202	.426202	.426202
53	ELECTROCARDIOLOGY	444,185	1,289,785	1,733,970	.132535	.132535	.132535
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	2,041,758	724,993	2,766,751	.274870	.274870	.274870
55	30 IMPL. DEV. CHARGED TO PAT	476,683	202,914	679,597	.421847	.421847	.421847
56	DRUGS CHARGED TO PATIENTS	9,320,313	4,069,873	13,390,186	.258001	.258001	.258001
57	RENAL DIALYSIS						
59	OP PSYCH		582,863	582,863	.525619	.525619	.525619
59	97 CARDIAC REHABILITATION						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	45,971	3,022,229	3,068,200	.757116	.757116	.757116
62	OBSERVATION BEDS (NON-DIS		1,334,648	1,334,648	.504910	.504910	.504910
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		2,572,022	2,572,022	.661783	.661783	.661783
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL		84,678	84,678	.060464	.060464	.060464
101	SUBTOTAL	36,419,540	50,270,020	86,689,560			
102	LESS OBSERVATION BEDS						
103	TOTAL	36,419,540	50,270,020	86,689,560			

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	4,866,824		4,866,824		4,866,824
26	INTENSIVE CARE UNIT	1,377,157		1,377,157		1,377,157
31	SUBPROVIDER	2,324,347		2,324,347		2,324,347
33	NURSERY	341,839		341,839		341,839
34	SKILLED NURSING FACILITY	2,488,280		2,488,280		2,488,280
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	3,324,998		3,324,998		3,324,998
38	RECOVERY ROOM					
39	DELIVERY ROOM & LABOR ROO	228,207		228,207		228,207
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	2,935,602		2,935,602		2,935,602
42	RADIOLOGY-THERAPEUTIC					
44	LABORATORY	3,120,136		3,120,136		3,120,136
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	637,602		637,602		637,602
50	PHYSICAL THERAPY	1,505,745		1,505,745		1,505,745
51	OCCUPATIONAL THERAPY	503,602		503,602		503,602
52	SPEECH PATHOLOGY	267,661		267,661		267,661
53	ELECTROCARDIOLOGY	229,812		229,812		229,812
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	760,496		760,496		760,496
55	30 IMPL. DEV. CHARGED TO PAT	286,686		286,686		286,686
56	DRUGS CHARGED TO PATIENTS	3,454,683		3,454,683		3,454,683
57	RENAL DIALYSIS					
59	OP PSYCH	306,364		306,364		306,364
59	97 CARDIAC REHABILITATION					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	2,322,983		2,322,983		2,322,983
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	673,877		673,877		673,877
65	AMBULANCE SERVICES	1,702,120		1,702,120		1,702,120
66	DURABLE MEDICAL EQUIP-REN	114,139		114,139		114,139
67	DURABLE MEDICAL EQUIP-SOL	5,120		5,120		5,120
101	SUBTOTAL	33,778,280		33,778,280		33,778,280
102	LESS OBSERVATION BEDS	673,877		673,877		673,877
103	TOTAL	33,104,403		33,104,403		33,104,403

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	6,171,685		6,171,685			
26	INTENSIVE CARE UNIT	2,200,608		2,200,608			
31	SUBPROVIDER	3,252,776		3,252,776			
33	NURSERY	242,143		242,143			
34	SKILLED NURSING FACILITY	1,896,045		1,896,045			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,281,032	4,685,776	5,966,808	.557249	.557249	.557249
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO	116,180	57,934	174,114	1.310676	1.310676	1.310676
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	1,876,411	16,594,943	18,471,354	.158927	.158927	.158927
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY	2,776,177	12,398,081	15,174,258	.205620	.205620	.205620
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	2,961,744	395,547	3,357,291	.189916	.189916	.189916
50	PHYSICAL THERAPY	748,112	1,235,228	1,983,340	.759197	.759197	.759197
51	OCCUPATIONAL THERAPY	377,207	581,001	958,208	.525566	.525566	.525566
52	SPEECH PATHOLOGY	190,510	437,505	628,015	.426202	.426202	.426202
53	ELECTROCARDIOLOGY	444,185	1,289,785	1,733,970	.132535	.132535	.132535
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	2,041,758	724,993	2,766,751	.274870	.274870	.274870
55	30 IMPL. DEV. CHARGED TO PAT	476,683	202,914	679,597	.421847	.421847	.421847
56	DRUGS CHARGED TO PATIENTS	9,320,313	4,069,873	13,390,186	.258001	.258001	.258001
57	RENAL DIALYSIS						
59	OP PSYCH		582,863	582,863	.525619	.525619	.525619
59	97 CARDIAC REHABILITATION						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	45,971	3,022,229	3,068,200	.757116	.757116	.757116
62	OBSERVATION BEDS (NON-DIS		1,334,648	1,334,648	.504910	.504910	.504910
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		2,572,022	2,572,022	.661783	.661783	.661783
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL		84,678	84,678	.060464	.060464	.060464
101	SUBTOTAL	36,419,540	50,270,020	86,689,560			
102	LESS OBSERVATION BEDS						
103	TOTAL	36,419,540	50,270,020	86,689,560			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	3,324,998	381,052	2,943,946			3,324,998
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO	228,207	5,001	223,206			228,207
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	2,935,602	323,935	2,611,667			2,935,602
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY	3,120,136	146,454	2,973,682			3,120,136
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	637,602	51,461	586,141			637,602
50	PHYSICAL THERAPY	1,505,745	202,462	1,303,283			1,505,745
51	OCCUPATIONAL THERAPY	503,602	18,614	484,988			503,602
52	SPEECH PATHOLOGY	267,661	7,833	259,828			267,661
53	ELECTROCARDIOLOGY	229,812	6,948	222,864			229,812
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	760,496	7,037	753,459			760,496
55	30 IMPL. DEV. CHARGED TO PAT	286,686	2,653	284,033			286,686
56	DRUGS CHARGED TO PATIENTS	3,454,683	78,750	3,375,933			3,454,683
57	RENAL DIALYSIS						
59	OP PSYCH	306,364	5,573	300,791			306,364
59	97 CARDIAC REHABILITATION OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	2,322,983	208,448	2,114,535			2,322,983
62	OBSERVATION BEDS (NON-DIS)	673,877		673,877			673,877
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	1,702,120	116,384	1,585,736			1,702,120
66	DURABLE MEDICAL EQUIP-REN	114,139	31,113	83,026			114,139
67	DURABLE MEDICAL EQUIP-SOL	5,120	196	4,924			5,120
101	SUBTOTAL	22,379,833	1,593,914	20,785,919			22,379,833
102	LESS OBSERVATION BEDS	673,877		673,877			673,877
103	TOTAL	21,705,956	1,593,914	20,112,042			21,705,956

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGR RATIO	I/P PT B COST TO CHRGR RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	5,966,808	.557249	.557249
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROO	174,114	1.310676	1.310676
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	18,471,354	.158927	.158927
42	RADIOLOGY-THERAPEUTIC			
44	LABORATORY	15,174,258	.205620	.205620
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	3,357,291	.189916	.189916
50	PHYSICAL THERAPY	1,983,340	.759197	.759197
51	OCCUPATIONAL THERAPY	958,208	.525566	.525566
52	SPEECH PATHOLOGY	628,015	.426202	.426202
53	ELECTROCARDIOLOGY	1,733,970	.132535	.132535
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	2,766,751	.274870	.274870
55	30 IMPL. DEV. CHARGED TO PAT	679,597	.421847	.421847
56	DRUGS CHARGED TO PATIENTS	13,390,186	.258001	.258001
57	RENAL DIALYSIS			
59	OP PSYCH	582,863	.525619	.525619
59	97 CARDIAC REHABILITATION			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	3,068,200	.757116	.757116
62	OBSERVATION BEDS (NON-DIS	1,334,648	.504910	.504910
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	2,572,022	.661783	.661783
66	DURABLE MEDICAL EQUIP-REN			
67	DURABLE MEDICAL EQUIP-SOL	84,678	.060464	.060464
101	SUBTOTAL	72,926,303		
102	LESS OBSERVATION BEDS	1,334,648		
103	TOTAL	71,591,655		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	3,324,998	381,052	2,943,946			3,324,998
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO	228,207	5,001	223,206			228,207
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	2,935,602	323,935	2,611,667			2,935,602
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY	3,120,136	146,454	2,973,682			3,120,136
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	637,602	51,461	586,141			637,602
50	PHYSICAL THERAPY	1,505,745	202,462	1,303,283			1,505,745
51	OCCUPATIONAL THERAPY	503,602	18,614	484,988			503,602
52	SPEECH PATHOLOGY	267,661	7,833	259,828			267,661
53	ELECTROCARDIOLOGY	229,812	6,948	222,864			229,812
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	760,496	7,037	753,459			760,496
55	30 IMPL. DEV. CHARGED TO PAT	286,686	2,653	284,033			286,686
56	DRUGS CHARGED TO PATIENTS	3,454,683	78,750	3,375,933			3,454,683
57	RENAL DIALYSIS						
59	OP PSYCH	306,364	5,573	300,791			306,364
59	97 CARDIAC REHABILITATION						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	2,322,983	208,448	2,114,535			2,322,983
62	OBSERVATION BEDS (NON-DIS	673,877		673,877			673,877
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	1,702,120	116,384	1,585,736			1,702,120
66	DURABLE MEDICAL EQUIP-REN	114,139	31,113	83,026			114,139
67	DURABLE MEDICAL EQUIP-SOL	5,120	196	4,924			5,120
101	SUBTOTAL	22,379,833	1,593,914	20,785,919			22,379,833
102	LESS OBSERVATION BEDS	673,877		673,877			673,877
103	TOTAL	21,705,956	1,593,914	20,112,042			21,705,956

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	5,966,808	.557249	.557249
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROO	174,114	1.310676	1.310676
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	18,471,354	.158927	.158927
42	RADIOLOGY-THERAPEUTIC			
44	LABORATORY	15,174,258	.205620	.205620
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	3,357,291	.189916	.189916
50	PHYSICAL THERAPY	1,983,340	.759197	.759197
51	OCCUPATIONAL THERAPY	958,208	.525566	.525566
52	SPEECH PATHOLOGY	628,015	.426202	.426202
53	ELECTROCARDIOLOGY	1,733,970	.132535	.132535
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	2,766,751	.274870	.274870
55	30 IMPL. DEV. CHARGED TO PAT	679,597	.421847	.421847
56	DRUGS CHARGED TO PATIENTS	13,390,186	.258001	.258001
57	RENAL DIALYSIS			
59	OP PSYCH	582,863	.525619	.525619
59	97 CARDIAC REHABILITATION			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	3,068,200	.757116	.757116
62	OBSERVATION BEDS (NON-DIS	1,334,648	.504910	.504910
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	2,572,022	.661783	.661783
66	DURABLE MEDICAL EQUIP-REN			
67	DURABLE MEDICAL EQUIP-SOL	84,678	.060464	.060464
101	SUBTOTAL	72,926,303		
102	LESS OBSERVATION BEDS	1,334,648		
103	TOTAL	71,591,655		

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
		CAPITAL REL COST (B, II) 1	SWING BED ADJUSTMENT 2	REDUCED CAP RELATED COST 3	CAPITAL REL COST (B, III) 4	SWING BED ADJUSTMENT 5	REDUCED CAP RELATED COST 6
25	INPAT ROUTINE SRVC CNTRS				734,983	843	734,140
26	ADULTS & PEDIATRICS				152,059		152,059
31	INTENSIVE CARE UNIT				263,167		263,167
33	SUBPROVIDER				17,942		17,942
101	NURSERY				1,168,151		1,167,308
	TOTAL						

TITLE XVIII, PART A

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	INPAT PROGRAM OLD CAP CST 10	NEW CAPITAL PER DIEM 11	INPAT PROGRAM NEW CAP CST 12
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	6,341	3,598			115.78	416,576
26	INTENSIVE CARE UNIT	731	345			208.02	71,767
31	SUBPROVIDER	2,333	56			112.80	6,317
33	NURSERY	366				49.02	
101	TOTAL	9,771	3,999				494,660

APPORTIONMENT OF INPATIENT ROUTINE  
SERVICE OTHER PASS THROUGH COSTS  
TITLE XVIII, PART A

I PROVIDER NO: 15-1330  
I PERIOD: FROM 1/ 1/2010 TO 12/31/2010  
I PREPARED 5/27/2011  
I WORKSHEET D  
I PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	MED EDUCATN COST 2	SWING BED ADJ AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS					6,341	
26	INTENSIVE CARE UNIT					731	
31	SUBPROVIDER					2,333	
33	NURSERY					366	
34	SKILLED NURSING FACILITY					4,284	
101	TOTAL					14,055	

APPORTIONMENT OF INPATIENT ROUTINE  
 SERVICE OTHER PASS THROUGH COSTS  
 TITLE XVIII, PART A

I PROVIDER NO: 15-1330  
 I PERIOD: FROM 1/ 1/2010 TO 12/31/2010  
 I PREPARED 5/27/2011  
 I WORKSHEET D  
 I PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT PROG DAYS	INPAT PROGRAM PASS THRU COST
		7	8
25	ADULTS & PEDIATRICS	3,598	
26	INTENSIVE CARE UNIT	345	
31	SUBPROVIDER	56	
33	NURSERY		
34	SKILLED NURSING FACILITY	2,753	
101	TOTAL	6,752	

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.557249		.557249		
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM	1.310676		1.310676		
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC	.158927		.158927		
42 RADIOLOGY-THERAPEUTIC					
44 LABORATORY	.205620		.205620		
48 INTRAVENOUS THERAPY					
49 RESPIRATORY THERAPY	.189916		.189916		
50 PHYSICAL THERAPY	.759197		.759197		
51 OCCUPATIONAL THERAPY	.525566		.525566		
52 SPEECH PATHOLOGY	.426202		.426202		
53 ELECTROCARDIOLOGY	.132535		.132535		
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.274870		.274870		
55 30 IMPL. DEV. CHARGED TO PATIENT	.421847		.421847		
56 DRUGS CHARGED TO PATIENTS	.258001		.258001		
57 RENAL DIALYSIS					
59 OP PSYCH	.525619		.525619		
59 97 CARDIAC REHABILITATION					
OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY	.757116		.757116		
62 OBSERVATION BEDS (NON-DISTINCT PART)	.504910		.504910		
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES	.661783		.661783		
66 DURABLE MEDICAL EQUIP-RENTED					
67 DURABLE MEDICAL EQUIP-SOLD	.060464		.060464		
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES					

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

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	4	5	6	7	8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		1,053,613			
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC		3,632,623			
42 RADIOLOGY-THERAPEUTIC					
44 LABORATORY		1,327,967			
48 INTRAVENOUS THERAPY					
49 RESPIRATORY THERAPY		114,348			
50 PHYSICAL THERAPY		570,184			
51 OCCUPATIONAL THERAPY		134,670			
52 SPEECH PATHOLOGY		29,928			
53 ELECTROCARDIOLOGY		991,159			
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		478,187			
55 30 IMPL. DEV. CHARGED TO PATIENT		60,734			
56 DRUGS CHARGED TO PATIENTS		1,446,097			
57 RENAL DIALYSIS					
59 OP PSYCH		50,584			
59 97 CARDIAC REHABILITATION					
60 OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY		808,520			
62 OBSERVATION BEDS (NON-DISTINCT PART)		548,715			
62 OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES					
66 DURABLE MEDICAL EQUIP-RENTED					
67 DURABLE MEDICAL EQUIP-SOLD					
101 SUBTOTAL		11,247,329			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		11,247,329			

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM	587,125		
38 RECOVERY ROOM			
39 DELIVERY ROOM & LABOR ROOM			
40 ANESTHESIOLOGY			
41 RADIOLOGY-DIAGNOSTIC	577,322		
42 RADIOLOGY-THERAPEUTIC			
44 LABORATORY	273,057		
48 INTRAVENOUS THERAPY			
49 RESPIRATORY THERAPY	21,717		
50 PHYSICAL THERAPY	432,882		
51 OCCUPATIONAL THERAPY	70,778		
52 SPEECH PATHOLOGY	12,755		
53 ELECTROCARDIOLOGY	131,363		
54 ELECTROENCEPHALOGRAPHY			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	131,439		
55 30 IMPL. DEV. CHARGED TO PATIENT	25,620		
56 DRUGS CHARGED TO PATIENTS	373,094		
57 RENAL DIALYSIS			
59 OP PSYCH	26,588		
59 97 CARDIAC REHABILITATION			
60 OUTPAT SERVICE COST CNTRS			
60 CLINIC			
61 EMERGENCY	612,143		
62 OBSERVATION BEDS (NON-DISTINCT PART)	277,052		
62 OTHER REIMBURS COST CNTRS			
65 AMBULANCE SERVICES			
66 DURABLE MEDICAL EQUIP-RENTED			
67 DURABLE MEDICAL EQUIP-SOLD			
101 SUBTOTAL	3,552,935		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS-			
PROGRAM ONLY CHARGES			
104 NET CHARGES	3,552,935		

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D  
 I COMPONENT NO: I TO 12/31/2010 I PART II  
 I 15-M330 I I

TITLE XVIII, PART A

SUBPROVIDER 1

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	OLD CAPITAL CST/CHRG RATIO 5	COSTS 6
37	ANCILLARY SRVC COST CNTRS						
38	OPERATING ROOM		381,052	5,966,808			
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO		5,001	174,114			
41	ANESTHESIOLOGY						
42	RADIOLOGY-DIAGNOSTIC		323,935	18,471,354	201		
44	RADIOLOGY-THERAPEUTIC						
48	LABORATORY		146,454	15,174,258	3,772		
49	INTRAVENOUS THERAPY						
50	RESPIRATORY THERAPY		51,461	3,357,291	1,991		
51	PHYSICAL THERAPY		202,462	1,983,340			
52	OCCUPATIONAL THERAPY		18,614	958,208	180		
53	SPEECH PATHOLOGY		7,833	628,015	1,184		
54	ELECTROCARDIOLOGY		6,948	1,733,970	752		
55	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED		7,037	2,766,751	6,203		
56	30 IMPL. DEV. CHARGED TO PAT		2,653	679,597			
57	DRUGS CHARGED TO PATIENTS		78,750	13,390,186	15,091		
59	RENAL DIALYSIS						
59	97 OP PSYCH		5,573	582,863			
60	CARDIAC REHABILITATION						
61	OUTPAT SERVICE COST CNTRS						
62	CLINIC						
62	EMERGENCY		208,448	3,068,200			
65	OBSERVATION BEDS (NON-DIS			1,334,648			
66	OTHER REIMBURS COST CNTRS						
67	AMBULANCE SERVICES						
101	DURABLE MEDICAL EQUIP-REN		31,113				
	DURABLE MEDICAL EQUIP-SOL		196	84,678			
	TOTAL		1,477,530	70,354,281	29,374		

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D  
 I COMPONENT NO: I TO 12/31/2010 I PART II  
 I 15-M330 I I

TITLE XVIII, PART A SUBPROVIDER 1

WKST A LINE NO.	COST CENTER DESCRIPTION	CST/CHRG 7	NEW CAPITAL RATIO	COSTS 8
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM		.063862	
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROO		.028723	
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC		.017537	4
42	RADIOLOGY-THERAPEUTIC			
44	LABORATORY		.009651	36
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY		.015328	31
50	PHYSICAL THERAPY		.102081	
51	OCCUPATIONAL THERAPY		.019426	3
52	SPEECH PATHOLOGY		.012473	15
53	ELECTROCARDIOLOGY		.004007	3
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED		.002543	16
55 30	IMPL. DEV. CHARGED TO PAT		.003904	
56	DRUGS CHARGED TO PATIENTS		.005881	89
57	RENAL DIALYSIS			
59	OP PSYCH		.009561	
59 97	CARDIAC REHABILITATION OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY		.067938	
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-REN			
67	DURABLE MEDICAL EQUIP-SOL		.002315	
101	TOTAL			197

PPS

TITLE XVIII, PART A

SUBPROVIDER 1

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST		MED ED NRS SCHOOL COST	MED ED ALLIED HEALTH COST	MED ED ALL OTHER COSTS	BLOOD CLOT FOR HEMOPHILIACS
		1	1.01	2	2.01	2.02	2.03
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY						
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED						
55	30 IMPL. DEV. CHARGED TO PAT						
56	DRUGS CHARGED TO PATIENTS						
57	RENAL DIALYSIS						
59	OP PSYCH						
59	97 CARDIAC REHABILITATION						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	TOTAL						

TITLE XVIII, PART A

SUBPROVIDER 1

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM			5,966,808				
38	RECOVERY ROOM							
39	DELIVERY ROOM & LABOR ROO			174,114				
40	ANESTHESIOLOGY							
41	RADIOLOGY-DIAGNOSTIC			18,471,354			201	
42	RADIOLOGY-THERAPEUTIC							
44	LABORATORY			15,174,258			3,772	
48	INTRAVENOUS THERAPY							
49	RESPIRATORY THERAPY			3,357,291			1,991	
50	PHYSICAL THERAPY			1,983,340				
51	OCCUPATIONAL THERAPY			958,208			180	
52	SPEECH PATHOLOGY			628,015			1,184	
53	ELECTROCARDIOLOGY			1,733,970			752	
54	ELECTROENCEPHALOGRAPHY							
55	MEDICAL SUPPLIES CHARGED			2,766,751			6,203	
55	30 IMPL. DEV. CHARGED TO PAT			679,597				
56	DRUGS CHARGED TO PATIENTS			13,390,186			15,091	
57	RENAL DIALYSIS							
59	OP PSYCH			582,863				
59	97 CARDIAC REHABILITATION							
	OUTPAT SERVICE COST CNTRS							
60	CLINIC							
61	EMERGENCY			3,068,200				
62	OBSERVATION BEDS (NON-DIS			1,334,648				
	OTHER REIMBURS COST CNTRS							
65	AMBULANCE SERVICES							
66	DURABLE MEDICAL EQUIP-REN							
67	DURABLE MEDICAL EQUIP-SOL			84,678				
101	TOTAL			70,354,281			29,374	

TITLE XVIII, PART A SUBPROVIDER 1 PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OUTPAT PROG CHARGES	OUTPAT PROG D,V COL 5.03	OUTPAT PROG D,V COL 5.04	OUTPAT PROG PASS THRU COST	COL 8.01 * COL 5	COL 8.02 * COL 5
	ANCILLARY SRVC COST CNTRS	8	8.01	8.02	9	9.01	9.02
37	OPERATING ROOM						
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY						
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED						
55	30 IMPL. DEV. CHARGED TO PAT						
56	DRUGS CHARGED TO PATIENTS						
57	RENAL DIALYSIS						
59	OP PSYCH						
59	97 CARDIAC REHABILITATION						
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
62	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	TOTAL						

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

PROVIDER NO: 15-1330  
 PERIOD: FROM 1/1/2010 TO 12/31/2010  
 COMPONENT NO: 15-5316  
 PREPARED 5/27/2011  
 WORKSHEET D  
 PART II

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	OLD CAPITAL CST/CHRG RATIO 5	COSTS 6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY						
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED						
55	30 IMPL. DEV. CHARGED TO PAT						
56	DRUGS CHARGED TO PATIENTS						
57	RENAL DIALYSIS						
59	OP PSYCH						
59	97 CARDIAC REHABILITATION						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	TOTAL						

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D  
 I COMPONENT NO: I TO 12/31/2010 I PART II  
 I 15-5316 I I

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

WKST A	COST CENTER DESCRIPTION	NEW CAPITAL
LINE NO.		CST/CHRG RATIO COSTS
		7 8
	ANCILLARY SRVC COST CNTRS	
37	OPERATING ROOM	
38	RECOVERY ROOM	
39	DELIVERY ROOM & LABOR ROO	
40	ANESTHESIOLOGY	
41	RADIOLOGY-DIAGNOSTIC	
42	RADIOLOGY-THERAPEUTIC	
44	LABORATORY	
48	INTRAVENOUS THERAPY	
49	RESPIRATORY THERAPY	
50	PHYSICAL THERAPY	
51	OCCUPATIONAL THERAPY	
52	SPEECH PATHOLOGY	
53	ELECTROCARDIOLOGY	
54	ELECTROENCEPHALOGRAPHY	
55	MEDICAL SUPPLIES CHARGED	
55	30 IMPL. DEV. CHARGED TO PAT	
56	DRUGS CHARGED TO PATIENTS	
57	RENAL DIALYSIS	
59	OP PSYCH	
59	97 CARDIAC REHABILITATION	
	OUTPAT SERVICE COST CNTRS	
60	CLINIC	
61	EMERGENCY	
62	OBSERVATION BEDS (NON-DIS	
	OTHER REIMBURS COST CNTRS	
65	AMBULANCE SERVICES	
66	DURABLE MEDICAL EQUIP-REN	
67	DURABLE MEDICAL EQUIP-SOL	
101	TOTAL	

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST		MED ED NRS SCHOOL COST	MED ED ALLIED HEALTH COST	MED ED ALL OTHER COSTS	BLOOD CLOT FOR HEMOPHILIACS
		1	1.01	2	2.01	2.02	2.03
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY						
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED						
55	30 IMPL. DEV. CHARGED TO PAT						
56	DRUGS CHARGED TO PATIENTS						
57	RENAL DIALYSIS						
59	OP PSYCH						
59	97 CARDIAC REHABILITATION						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	TOTAL						

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM			5,966,808				
38	RECOVERY ROOM							
39	DELIVERY ROOM & LABOR ROO			174,114				
40	ANESTHESIOLOGY							
41	RADIOLOGY-DIAGNOSTIC			18,471,354			42,480	
42	RADIOLOGY-THERAPEUTIC							
44	LABORATORY			15,174,258			182,886	
48	INTRAVENOUS THERAPY							
49	RESPIRATORY THERAPY			3,357,291			247,355	
50	PHYSICAL THERAPY			1,983,340			377,077	
51	OCCUPATIONAL THERAPY			958,208			216,455	
52	SPEECH PATHOLOGY			628,015			82,336	
53	ELECTROCARDIOLOGY			1,733,970			5,277	
54	ELECTROENCEPHALOGRAPHY							
55	MEDICAL SUPPLIES CHARGED			2,766,751			452,751	
55	30 IMPL. DEV. CHARGED TO PAT			679,597				
56	DRUGS CHARGED TO PATIENTS			13,390,186			1,446,821	
57	RENAL DIALYSIS							
59	OP PSYCH			582,863				
59	97 CARDIAC REHABILITATION							
	OUTPAT SERVICE COST CNTRS							
60	CLINIC							
61	EMERGENCY			3,068,200				
62	OBSERVATION BEDS (NON-DIS			1,334,648				
	OTHER REIMBURS COST CNTRS							
65	AMBULANCE SERVICES							
66	DURABLE MEDICAL EQUIP-REN			84,678				
67	DURABLE MEDICAL EQUIP-SOL							
101	TOTAL			70,354,281			3,053,438	

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OUTPAT PROG CHARGES	OUTPAT PROG D,V COL 5.03	OUTPAT PROG D,V COL 5.04	OUTPAT PROG PASS THRU COST	COL 8.01 * COL 5	COL 8.02 * COL 5
	ANCILLARY SRVC COST CNTRS	8	8.01	8.02	9	9.01	9.02
37	OPERATING ROOM						
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY						
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED						
55	30 IMPL. DEV. CHARGED TO PAT						
56	DRUGS CHARGED TO PATIENTS						
57	RENAL DIALYSIS						
59	OP PSYCH						
59	97 CARDIAC REHABILITATION						
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
62	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	TOTAL						

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D  
 I I TO 12/31/2010 I PART I

TITLE XIX

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
		CAPITAL REL COST (B, II) 1	SWING BED ADJUSTMENT 2	REDUCED CAP RELATED COST 3	CAPITAL REL COST (B, III) 4	SWING BED ADJUSTMENT 5	REDUCED CAP RELATED COST 6
25	INPAT ROUTINE SRVC CNTRS				734,983		734,983
26	ADULTS & PEDIATRICS				152,059		152,059
31	INTENSIVE CARE UNIT				263,167		263,167
33	SUBPROVIDER				17,942		17,942
101	NURSERY						
	TOTAL				1,168,151		1,168,151



APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D  
 I I TO 12/31/2010 I PART I

TITLE XIX

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
		CAPITAL REL COST (B, II) 1	SWING BED ADJUSTMENT 2	REDUCED CAP RELATED COST 3	CAPITAL REL COST (B, III) 4	SWING BED ADJUSTMENT 5	REDUCED CAP RELATED COST 6
25	ADULTS & PEDIATRICS				734,983		734,983
26	INTENSIVE CARE UNIT				152,059		152,059
31	SUBPROVIDER				263,167		263,167
33	NURSERY				17,942		17,942
101	TOTAL				1,168,151		1,168,151

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D  
 I I TO 12/31/2010 I PART I

TITLE XIX

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	INPAT PROGRAM OLD CAP CST 10	NEW CAPITAL PER DIEM 11	INPAT PROGRAM NEW CAP CST 12
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	6,341	304			115.91	35,237
26	INTENSIVE CARE UNIT	731	81			208.02	16,850
31	SUBPROVIDER	2,333	209			112.80	23,575
33	NURSERY	366	122			49.02	5,980
101	TOTAL	9,771	716				81,642

WKST A LINE NO.	COST CENTER DESCRIPTION	HOSPITAL		TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	OLD CAPITAL CST/CHRG RATIO 5	OLD CAPITAL COSTS 6
		OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2				
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM		381,052	5,966,808	134,443		
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO		5,001	174,114	42,507		
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC		323,935	18,471,354	72,654		
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY		146,454	15,174,258	216,162		
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY		51,461	3,357,291	98,706		
50	PHYSICAL THERAPY		202,462	1,983,340	6,599		
51	OCCUPATIONAL THERAPY		18,614	958,208	2,426		
52	SPEECH PATHOLOGY		7,833	628,015	547		
53	ELECTROCARDIOLOGY		6,948	1,733,970	51,521		
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED		7,037	2,766,751	150,375		
55	30 IMPL. DEV. CHARGED TO PAT		2,653	679,597			
56	DRUGS CHARGED TO PATIENTS		78,750	13,390,186	320,843		
57	RENAL DIALYSIS						
59	OP PSYCH		5,573	582,863			
59	97 CARDIAC REHABILITATION						
60	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY		208,448	3,068,200	13,040		
62	OBSERVATION BEDS (NON-DIS			1,334,648			
62	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN		31,113				
67	DURABLE MEDICAL EQUIP-SOL		196	84,678			
101	TOTAL		1,477,530	70,354,281	1,109,823		

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D  
 I COMPONENT NO: I TO 12/31/2010 I PART II  
 I 15-1330 I PPS I

TITLE XIX HOSPITAL

WKST A LINE NO.	COST CENTER DESCRIPTION	CST/CHRG 7	NEW CAPITAL RATIO	COSTS 8
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.063862		8,586
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROO	.028723		1,221
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.017537		1,274
42	RADIOLOGY-THERAPEUTIC			
44	LABORATORY	.009651		2,086
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	.015328		1,513
50	PHYSICAL THERAPY	.102081		674
51	OCCUPATIONAL THERAPY	.019426		47
52	SPEECH PATHOLOGY	.012473		7
53	ELECTROCARDIOLOGY	.004007		206
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	.002543		382
55	30 IMPL. DEV. CHARGED TO PAT	.003904		
56	DRUGS CHARGED TO PATIENTS	.005881		1,887
57	RENAL DIALYSIS			
59	OP PSYCH	.009561		
59	97 CARDIAC REHABILITATION			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.067938		886
62	OBSERVATION BEDS (NON-DIS			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-REN			
67	DURABLE MEDICAL EQUIP-SOL	.002315		
101	TOTAL			18,769

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D  
 I TO 12/31/2010 I PART III

APPORTIONMENT OF INPATIENT ROUTINE  
 SERVICE OTHER PASS THROUGH COSTS  
 TITLE XIX

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	MED EDUCATN COST 2	SWING BED ADJ AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS					6,341	
26	INTENSIVE CARE UNIT					731	
31	SUBPROVIDER					2,333	
33	NURSERY					366	
34	SKILLED NURSING FACILITY					4,284	
101	TOTAL					14,055	

APPORTIONMENT OF INPATIENT ROUTINE  
 SERVICE OTHER PASS THROUGH COSTS  
 TITLE XIX

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D  
 I I TO 12/31/2010 I PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT PROG DAYS 7	INPAT PROGRAM PASS THRU COST 8
25	ADULTS & PEDIATRICS		304
26	INTENSIVE CARE UNIT		81
31	SUBPROVIDER		209
33	NURSERY		122
34	SKILLED NURSING FACILITY		
101	TOTAL		716

APPORTIONMENT OF INPATIENT ROUTINE  
SERVICE OTHER PASS THROUGH COSTS  
TITLE XIX

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D  
I I TO 12/31/2010 I PART III  
PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	MED EDUCATN COST 2	SWING BED ADJ AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS					6,341	
26	INTENSIVE CARE UNIT					731	
31	SUBPROVIDER					2,333	
33	NURSERY					366	
34	SKILLED NURSING FACILITY					4,284	
101	TOTAL					14,055	

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D  
 I I TO 12/31/2010 I PART III

APPORTIONMENT OF INPATIENT ROUTINE  
 SERVICE OTHER PASS THROUGH COSTS  
 TITLE XIX

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT PROG DAYS	INPAT PROGRAM PASS THRU COST
		7	8
25	ADULTS & PEDIATRICS		304
26	INTENSIVE CARE UNIT		81
31	SUBPROVIDER		209
33	NURSERY		122
34	SKILLED NURSING FACILITY		
101	TOTAL		716

TITLE XIX HOSPITAL PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST	HOSPITAL	MED ED NRS SCHOOL COST	MED ED ALLIED HEALTH COST	MED ED ALL OTHER COSTS	BLOOD CLOT FOR HEMOPHILIACS
		1	1.01	2	2.01	2.02	2.03
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY						
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED						
55	30 IMPL. DEV. CHARGED TO PAT						
56	DRUGS CHARGED TO PATIENTS						
57	RENAL DIALYSIS						
59	OP PSYCH						
59	97 CARDIAC REHABILITATION						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	TOTAL						

TITLE XIX		HOSPITAL			PPS				
WKST A	COST CENTER DESCRIPTION	TOTAL COSTS	O/P PASS THRU COSTS	TOTAL CHARGES	RATIO OF COST TO CHARGES	O/P RATIO OF CST TO CHARGES	INPAT PROG CHARGE	INPAT PROG PASS THRU COST	
LINE NO.		3	3.01	4	5	5.01	6	7	
	ANCILLARY SRVC COST CNTRS								
37	OPERATING ROOM			5,966,808			134,443		
38	RECOVERY ROOM								
39	DELIVERY ROOM & LABOR ROO			174,114			42,507		
40	ANESTHESIOLOGY								
41	RADIOLOGY-DIAGNOSTIC			18,471,354			72,654		
42	RADIOLOGY-THERAPEUTIC								
44	LABORATORY			15,174,258			216,162		
48	INTRAVENOUS THERAPY								
49	RESPIRATORY THERAPY			3,357,291			98,706		
50	PHYSICAL THERAPY			1,983,340			6,599		
51	OCCUPATIONAL THERAPY			958,208			2,426		
52	SPEECH PATHOLOGY			628,015			547		
53	ELECTROCARDIOLOGY			1,733,970			51,521		
54	ELECTROENCEPHALOGRAPHY								
55	MEDICAL SUPPLIES CHARGED			2,766,751			150,375		
55	30 IMPL. DEV. CHARGED TO PAT			679,597					
56	DRUGS CHARGED TO PATIENTS			13,390,186			320,843		
57	RENAL DIALYSIS								
59	OP PSYCH			582,863					
59	97 CARDIAC REHABILITATION								
60	OUTPAT SERVICE COST CNTRS								
60	CLINIC								
61	EMERGENCY			3,068,200			13,040		
62	OBSERVATION BEDS (NON-DIS			1,334,648					
62	OTHER REIMBURS COST CNTRS								
65	AMBULANCE SERVICES								
66	DURABLE MEDICAL EQUIP-REN								
67	DURABLE MEDICAL EQUIP-SOL			84,678					
101	TOTAL			70,354,281			1,109,823		

TITLE XIX HOSPITAL PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OUTPAT PROG CHARGES	OUTPAT PROG D,V COL 5.03	OUTPAT PROG D,V COL 5.04	OUTPAT PROG PASS THRU COST	COL 8.01 * COL 5	COL 8.02 * COL 5
	ANCILLARY SRVC COST CNTRS	8	8.01	8.02	9	9.01	9.02
37	OPERATING ROOM						
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY						
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED						
55	30 IMPL. DEV. CHARGED TO PAT						
56	DRUGS CHARGED TO PATIENTS						
57	RENAL DIALYSIS						
59	OP PSYCH						
59	97 CARDIAC REHABILITATION						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	TOTAL						

TITLE XIX

SUBPROVIDER 1

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	OLD CAPITAL CST/CHRG RATIO 5	COSTS 6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM		381,052	5,966,808			
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO		5,001	174,114			
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC		323,935	18,471,354	493		
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY		146,454	15,174,258	19,614		
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY		51,461	3,357,291	650		
50	PHYSICAL THERAPY		202,462	1,983,340			
51	OCCUPATIONAL THERAPY		18,614	958,208			
52	SPEECH PATHOLOGY		7,833	628,015			
53	ELECTROCARDIOLOGY		6,948	1,733,970	4,649		
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED		7,037	2,766,751	1,397		
55	30 IMPL. DEV. CHARGED TO PAT		2,653	679,597			
56	DRUGS CHARGED TO PATIENTS		78,750	13,390,186	32,377		
57	RENAL DIALYSIS						
59	OP PSYCH		5,573	582,863			
59	97 CARDIAC REHABILITATION						
60	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY		208,448	3,068,200	188		
62	OBSERVATION BEDS (NON-DIS			1,334,648			
62	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN		31,113				
67	DURABLE MEDICAL EQUIP-SOL		196	84,678			
101	TOTAL		1,477,530	70,354,281	59,368		

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D  
 I COMPONENT NO: I TO 12/31/2010 I PART II  
 I 15-M330 I I

TITLE XIX

SUBPROVIDER 1

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	CST/CHRG 7	NEW CAPITAL RATIO	COSTS 8
37	ANCILLARY SRVC COST CNTRS		.063862	
38	OPERATING ROOM			
39	RECOVERY ROOM			
40	DELIVERY ROOM & LABOR ROO		.028723	
41	ANESTHESIOLOGY			
42	RADIOLOGY-DIAGNOSTIC		.017537	9
44	RADIOLOGY-THERAPEUTIC			
48	LABORATORY		.009651	189
49	INTRAVENOUS THERAPY			
50	RESPIRATORY THERAPY		.015328	.10
51	PHYSICAL THERAPY		.102081	
52	OCCUPATIONAL THERAPY		.019426	
53	SPEECH PATHOLOGY		.012473	
54	ELECTROCARDIOLOGY		.004007	19
55	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED		.002543	4
56	30 IMPL. DEV. CHARGED TO PAT		.003904	
57	DRUGS CHARGED TO PATIENTS		.005881	190
59	RENAL DIALYSIS			
59	OP. PSYCH		.009561	
59	97 CARDIAC REHABILITATION			
60	OUTPAT SERVICE COST CNTRS			
61	CLINIC			
61	EMERGENCY		.067938	13
62	OBSERVATION BEDS (NON-DIS			
65	OTHER REIMBURS COST CNTRS			
66	AMBULANCE SERVICES			
67	DURABLE MEDICAL EQUIP-REN			
67	DURABLE MEDICAL EQUIP-SOL		.002315	
101	TOTAL			434

TITLE XIX

SUBPROVIDER 1

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST	1	1.01	MED ED NRS SCHOOL COST	2	MED ED ALLIED HEALTH COST	2.01	MED ED ALL OTHER COSTS	2.02	BLOOD CLOT FOR HEMOPHILIACS	2.03
	ANCILLARY SRVC COST CNTRS											
37	OPERATING ROOM											
38	RECOVERY ROOM											
39	DELIVERY ROOM & LABOR ROO											
40	ANESTHESIOLOGY											
41	RADIOLOGY-DIAGNOSTIC											
42	RADIOLOGY-THERAPEUTIC											
44	LABORATORY											
48	INTRAVENOUS THERAPY											
49	RESPIRATORY THERAPY											
50	PHYSICAL THERAPY											
51	OCCUPATIONAL THERAPY											
52	SPEECH PATHOLOGY											
53	ELECTROCARDIOLOGY											
54	ELECTROENCEPHALOGRAPHY											
55	MEDICAL SUPPLIES CHARGED											
55	30 IMPL. DEV. CHARGED TO PAT											
56	DRUGS CHARGED TO PATIENTS											
57	RENAL DIALYSIS											
59	OP PSYCH											
59	97 CARDIAC REHABILITATION											
	OUTPAT SERVICE COST CNTRS											
60	CLINIC											
61	EMERGENCY											
62	OBSERVATION BEDS (NON-DIS											
	OTHER REIMBURS COST CNTRS											
65	AMBULANCE SERVICES											
66	DURABLE MEDICAL EQUIP-REN											
67	DURABLE MEDICAL EQUIP-SOL											
101	TOTAL											

TITLE XIX

SUBPROVIDER 1

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM			5,966,808				
38	RECOVERY ROOM							
39	DELIVERY ROOM & LABOR ROO			174,114				
40	ANESTHESIOLOGY							
41	RADIOLOGY-DIAGNOSTIC			18,471,354			493	
42	RADIOLOGY-THERAPEUTIC							
44	LABORATORY			15,174,258			19,614	
48	INTRAVENOUS THERAPY							
49	RESPIRATORY THERAPY			3,357,291			650	
50	PHYSICAL THERAPY			1,983,340				
51	OCCUPATIONAL THERAPY			958,208				
52	SPEECH PATHOLOGY			628,015				
53	ELECTROCARDIOLOGY			1,733,970			4,649	
54	ELECTROENCEPHALOGRAPHY							
55	MEDICAL SUPPLIES CHARGED			2,766,751			1,397	
55	30 IMPL. DEV. CHARGED TO PAT			679,597				
56	DRUGS CHARGED TO PATIENTS			13,390,186			32,377	
57	RENAL DIALYSIS							
59	OP PSYCH			582,863				
59	97 CARDIAC REHABILITATION							
	OUTPAT SERVICE COST CNTRS							
60	CLINIC							
61	EMERGENCY			3,068,200			188	
62	OBSERVATION BEDS (NON-DIS			1,334,648				
	OTHER REIMBURS COST CNTRS							
65	AMBULANCE SERVICES							
66	DURABLE MEDICAL EQUIP-REN							
67	DURABLE MEDICAL EQUIP-SOL			84,678				
101	TOTAL			70,354,281			59,368	

TITLE XIX

SUBPROVIDER 1

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OUTPAT PROG CHARGES	OUTPAT PROG D,V COL 5.03	OUTPAT PROG D,V COL 5.04	OUTPAT PROG PASS THRU COST	COL 8.01 * COL 5	COL 8.02 * COL 5
	ANCILLARY SRVC COST CNTRS	8	8.01	8.02	9	9.01	9.02
37	OPERATING ROOM						
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY						
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED						
55	30 IMPL. DEV. CHARGED TO PAT						
56	DRUGS CHARGED TO PATIENTS						
57	RENAL DIALYSIS						
59	OP PSYCH						
59	97 CARDIAC REHABILITATION						
60	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
62	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	TOTAL						

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)	6,381
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,341
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,341
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	40
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)	3,598
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	139.61
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	4,866,824
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	5,584
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	5,584
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,861,240

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	6,413,828
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	6,413,828
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.757931
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,011.49
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	4,861,240

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	766.64
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	2,758,371
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	2,758,371

	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	1,377,157	731	1,883.94	345	649,959
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				

1

2,040,035  
 5,448,365

PASS THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D-1  
 I COMPONENT NO: I TO 12/31/2010 I PART III  
 I 15-1330 I I

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	879
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	766.64
85	OBSERVATION BED COST	673,877

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 XVIII PART A SUBPROVIDER I PPS

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	2,333
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,333
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,333
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	56
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,324,347
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,324,347

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,252,776
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,252,776
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.714573
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,394.25
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	2,324,347

TITLE XVIII PART A SUBPROVIDER I PPS

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	996.29
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	55,792
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	55,792

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY) INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS				
43	INTENSIVE CARE UNIT				
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				1 7,484
49	TOTAL PROGRAM INPATIENT COSTS				63,276

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	6,317
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	197
52	TOTAL PROGRAM EXCLUDABLE COST	6,514
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	56,762

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 XVIII PART A SUBPROVIDER I PPS

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	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	996.29
85	OBSERVATION BED COST	

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	1	2	3	4	5
	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
86	OLD CAPITAL-RELATED COST	2,324,347			
87	NEW CAPITAL-RELATED COST	263,167	.113222		
88	NON PHYSICIAN ANESTHETIST	2,324,347			
89	MEDICAL EDUCATION	2,324,347			
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

TITLE XVIII PART A SNF PPS

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	4,284
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,284
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,284
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,753
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,488,280
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,488,280

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,896,045
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,896,045
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.312353
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	442.59
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	2,488,280

TITLE XVIII PART A SNF PPS

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

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1	2,488,280
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	580.83	
68	PROGRAM ROUTINE SERVICE COST	1,599,025	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	1,599,025	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	399,496	
72	PER DIEM CAPITAL-RELATED COSTS	93.25	
73	PROGRAM CAPITAL-RELATED COSTS	256,717	
74	INPATIENT ROUTINE SERVICE COST	1,342,308	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	1,342,308	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		
78	INPATIENT ROUTINE SERVICE COST LIMITATION		
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	1,599,025	
80	PROGRAM INPATIENT ANCILLARY SERVICES	1,024,890	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION		
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	2,623,915	

PART IV - COMPUTATION OF OBSERVATION BED COST

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

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D-4  
 I COMPONENT NO: I TO 12/31/2010 I  
 I 15-1330 I

TITLE XVIII, PART A

HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		4,545,748	
26	INTENSIVE CARE UNIT		752,100	
31	SUBPROVIDER ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.557249	222,806	124,158
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM	1.310676		
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.158927	637,005	101,237
42	RADIOLOGY-THERAPEUTIC			
44	LABORATORY	.205620	1,167,748	240,112
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	.189916	621,546	118,042
50	PHYSICAL THERAPY	.759197	88,944	67,526
51	OCCUPATIONAL THERAPY	.525566	28,659	15,062
52	SPEECH PATHOLOGY	.426202	52,733	22,475
53	ELECTROCARDIOLOGY	.132535	359,179	47,604
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.274870	1,431,032	393,348
55	30 IMPL. DEV. CHARGED TO PATIENT	.421847		
56	DRUGS CHARGED TO PATIENTS	.258001	3,511,479	905,965
57	RENAL DIALYSIS			
59	OP PSYCH	.525619		
59	97 CARDIAC REHABILITATION OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.757116	5,951	4,506
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS	.504910		
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD	.060464		
101	TOTAL		8,127,082	2,040,035
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		8,127,082	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D-4  
 I COMPONENT NO: I TO 12/31/2010 I  
 I 15-M330 I

TITLE XVIII, PART A

SUBPROVIDER 1

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
31	SUBPROVIDER		70,851	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.557249		
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM	1.310676		
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.158927	201	32
42	RADIOLOGY-THERAPEUTIC			
44	LABORATORY	.205620	3,772	776
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	.189916	1,991	378
50	PHYSICAL THERAPY	.759197		
51	OCCUPATIONAL THERAPY	.525566	180	95
52	SPEECH PATHOLOGY	.426202	1,184	505
53	ELECTROCARDIOLOGY	.132535	752	100
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.274870	6,203	1,705
55	30 IMPL. DEV. CHARGED TO PATIENT	.421847		
56	DRUGS CHARGED TO PATIENTS	.258001	15,091	3,893
57	RENAL DIALYSIS			
59	OP PSYCH	.525619		
59	97 CARDIAC REHABILITATION			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.757116		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.504910		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD	.060464		
101	TOTAL		29,374	7,484
102	LESS PBP CLINIC LABORATORY SERVICES -			
	PROGRAM ONLY CHARGES			
103	NET CHARGES		29,374	

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
31	SUBPROVIDER			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.557249		
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM	1.310676		
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.158927	42,480	6,751
42	RADIOLOGY-THERAPEUTIC			
44	LABORATORY	.205620	182,886	37,605
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	.189916	247,355	46,977
50	PHYSICAL THERAPY	.759197	377,077	286,276
51	OCCUPATIONAL THERAPY	.525566	216,455	113,761
52	SPEECH PATHOLOGY	.426202	82,336	35,092
53	ELECTROCARDIOLOGY	.132535	5,277	699
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.274870	452,751	124,448
55	30 IMPL. DEV. CHARGED TO PATIENT	.421847		
56	DRUGS CHARGED TO PATIENTS	.258001	1,446,821	373,281
57	RENAL DIALYSIS			
59	OP PSYCH	.525619		
59	97 CARDIAC REHABILITATION			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.757116		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.504910		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD	.060464		
101	TOTAL		3,053,438	1,024,890
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		3,053,438	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D-4  
 I COMPONENT NO: I TO 12/31/2010 I  
 I 15-1330 I

TITLE XIX HOSPITAL PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		515,050	
26	INTENSIVE CARE UNIT		165,680	
31	SUBPROVIDER ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.557249	134,443	74,918
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM	1.310676	42,507	55,713
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.158927	72,654	11,547
42	RADIOLOGY-THERAPEUTIC			
44	LABORATORY	.205620	216,162	44,447
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	.189916	98,706	18,746
50	PHYSICAL THERAPY	.759197	6,599	5,010
51	OCCUPATIONAL THERAPY	.525566	2,426	1,275
52	SPEECH PATHOLOGY	.426202	547	233
53	ELECTROCARDIOLOGY	.132535	51,521	6,828
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.274870	150,375	41,334
55	30 IMPL. DEV. CHARGED TO PATIENT	.421847		
56	DRUGS CHARGED TO PATIENTS	.258001	320,843	82,778
57	RENAL DIALYSIS			
59	OP PSYCH	.525619		
59	97 CARDIAC REHABILITATION OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.757116	13,040	9,873
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS	.504910		
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD	.060464		
101	TOTAL		1,109,823	352,702
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,109,823	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET D-4  
 I COMPONENT NO: I TO 12/31/2010 I  
 I 15-M330 I

TITLE XIX

SUBPROVIDER 1

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
31	SUBPROVIDER		258,587	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.557249		
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM	1.310676		
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.158927	493	78
42	RADIOLOGY-THERAPEUTIC			
44	LABORATORY	.205620	19,614	4,033
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	.189916	650	123
50	PHYSICAL THERAPY	.759197		
51	OCCUPATIONAL THERAPY	.525566		
52	SPEECH PATHOLOGY	.426202		
53	ELECTROCARDIOLOGY	.132535	4,649	616
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.274870	1,397	384
55	30 IMPL. DEV. CHARGED TO PATIENT	.421847		
56	DRUGS CHARGED TO PATIENTS	.258001	32,377	8,353
57	RENAL DIALYSIS			
59	OP PSYCH	.525619		
59	97 CARDIAC REHABILITATION			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.757116	188	142
62	OBSERVATION BEDS (NON-DISTINCT PART)	.504910		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD	.060464		
101	TOTAL		59,368	13,729
102	LESS PBP CLINIC LABORATORY SERVICES -			
	PROGRAM ONLY CHARGES			
103	NET CHARGES		59,368	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET E  
 I COMPONENT NO: I TO 12/31/2010 I PART B  
 I 15-1330 I I

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) 3,552,935  
 1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1,  
 2001 (SEE INSTRUCTIONS).  
 1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.  
 1.03 ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.  
 1.04 LINE 1.01 TIMES LINE 1.03.  
 1.05 LINE 1.02 DIVIDED BY LINE 1.04.  
 1.06 TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)  
 1.07 OUTPATIENT ANCILLARY PASSTHRU COSTS FROM (W/S D,IV  
 (COLS 9, 9.01, 9.02) LINE 101  
 2 INTERNS AND RESIDENTS  
 3 ORGAN ACQUISITIONS  
 4 COST OF TEACHING PHYSICIANS  
 5 TOTAL COST (SEE INSTRUCTIONS) 3,552,935

COMPUTATION OF LESSER OF COST OR CHARGES

REASONABLE CHARGES  
 6 ANCILLARY SERVICE CHARGES  
 7 INTERNS AND RESIDENTS SERVICE CHARGES  
 8 ORGAN ACQUISITION CHARGES  
 9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.  
 10 TOTAL REASONABLE CHARGES  
 CUSTOMARY CHARGES  
 11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR  
 PAYMENT FOR SERVICES ON A CHARGE BASIS  
 12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE  
 FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT  
 BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).  
 13 RATIO OF LINE 11 TO LINE 12  
 14 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)  
 15 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST  
 16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES  
 17 LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC) 3,588,464  
 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18 CAH DEDUCTIBLES 41,343  
 18.01 CAH ACTUAL BILLED COINSURANCE 1,993,106  
 LINE 17.01 (SEE INSTRUCTIONS)  
 19 SUBTOTAL (SEE INSTRUCTIONS) 1,554,015  
 20 SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)  
 21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS  
 22 ESRD DIRECT MEDICAL EDUCATION COSTS  
 23 SUBTOTAL 1,554,015  
 24 PRIMARY PAYER PAYMENTS 804  
 25 SUBTOTAL 1,553,211

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26 COMPOSITE RATE ESRD  
 27 BAD DEBTS (SEE INSTRUCTIONS) 7,456  
 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) 7,456  
 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES 7,456  
 28 SUBTOTAL 1,560,667  
 29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER  
 TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.  
 30 OTHER ADJUSTMENTS (SPECIFY)  
 30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)  
 31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING  
 FROM DISPOSITION OF DEPRECIABLE ASSETS.  
 32 SUBTOTAL 1,560,667  
 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)  
 34 INTERIM PAYMENTS 1,903,159  
 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)  
 35 BALANCE DUE PROVIDER/PROGRAM -342,492  
 36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)  
 IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2

TO BE COMPLETED BY CONTRACTOR

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET E-1  
 I COMPONENT NO: I TO 12/31/2010 I  
 I 15-1330 I I

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		5,277,587		2,040,729
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER	.01	8/12/2010 317,832		
ADJUSTMENTS TO PROVIDER	.02	12/23/2010 88,656		
ADJUSTMENTS TO PROVIDER	.03			
ADJUSTMENTS TO PROVIDER	.04			
ADJUSTMENTS TO PROVIDER	.05			
ADJUSTMENTS TO PROVIDER	.49			
ADJUSTMENTS TO PROGRAM	.50		8/12/2010 106,030	
ADJUSTMENTS TO PROGRAM	.51		12/23/2010 31,540	
ADJUSTMENTS TO PROGRAM	.52			
ADJUSTMENTS TO PROGRAM	.53			
ADJUSTMENTS TO PROGRAM	.54			
SUBTOTAL	.99	406,488		-137,570
4 TOTAL INTERIM PAYMENTS		5,684,075		1,903,159
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	780,039		342,492
7 TOTAL MEDICARE PROGRAM LIABILITY		4,904,036		1,560,667

NAME OF INTERMEDIARY:  
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET E-1  
 I COMPONENT NO: I TO 12/31/2010 I  
 I 15-M330 I I

TITLE XVIII SUBPROVIDER 1

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		41,717		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER		.01		
ADJUSTMENTS TO PROVIDER		.02		
ADJUSTMENTS TO PROVIDER		.03		
ADJUSTMENTS TO PROVIDER		.04		
ADJUSTMENTS TO PROVIDER		.05		
ADJUSTMENTS TO PROVIDER		.49		
ADJUSTMENTS TO PROGRAM		.50		
ADJUSTMENTS TO PROGRAM		.51		
ADJUSTMENTS TO PROGRAM		.52		
ADJUSTMENTS TO PROGRAM		.53		
ADJUSTMENTS TO PROGRAM		.54		
SUBTOTAL		.99	NONE	NONE
4 TOTAL INTERIM PAYMENTS			41,717	
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		
7 TOTAL MEDICARE PROGRAM LIABILITY			41,717	

NAME OF INTERMEDIARY:  
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET E-1  
 I COMPONENT NO: I TO 12/31/2010 I  
 I 15-5316 I I

TITLE XVIII SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		855,425		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER		.01		
ADJUSTMENTS TO PROVIDER		.02		
ADJUSTMENTS TO PROVIDER		.03		
ADJUSTMENTS TO PROVIDER		.04		
ADJUSTMENTS TO PROVIDER		.05		
ADJUSTMENTS TO PROVIDER		.49		
ADJUSTMENTS TO PROGRAM		.50		
ADJUSTMENTS TO PROGRAM		.51		
ADJUSTMENTS TO PROGRAM		.52		
ADJUSTMENTS TO PROGRAM		.53		
ADJUSTMENTS TO PROGRAM		.54		
SUBTOTAL		.99		
4 TOTAL INTERIM PAYMENTS			NONE	NONE
			855,425	
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		
7 TOTAL MEDICARE PROGRAM LIABILITY			855,425	

NAME OF INTERMEDIARY:  
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

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

CALCULATION OF REIMBURSEMENT SETTLEMENT  
SWING BEDS

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/27/2011
I	15-1330	I	FROM 1/ 1/2010	I		
I	COMPONENT NO:	I	TO 12/31/2010	I	WORKSHEET E-2	
I	15-Z330	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)
- 2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)
- 3 ANCILLARY SERVICES (SEE INSTRUCTIONS)
- 4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED  
TEACHING PROGRAM (SEE INSTRUCTIONS)
- 5 PROGRAM DAYS
- 6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM  
(SEE INSTRUCTIONS)
- 7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL  
METHOD ONLY
- 8 SUBTOTAL
- 9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)
- 10 SUBTOTAL
- 11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS  
APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)
- 12 SUBTOTAL
- 13 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER  
RECORDS) (EXCLUDE COINSURANCE FOR PHYSICIAN  
PROFESSIONAL SERVICES)
- 14 80% OF PART B COSTS
- 15 SUBTOTAL
- 16 OTHER ADJUSTMENTS (SPECIFY)
- 17 REIMBURSABLE BAD DEBTS
- 17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES  
(SEE INSTRUCTIONS)
- 18 TOTAL
- 19 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)
- 20 INTERIM PAYMENTS
- 20.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)
- 21 BALANCE DUE PROVIDER/PROGRAM
- 22 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)  
IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET E-3  
 I COMPONENT NO: I TO 12/31/2010 I PART I  
 I 15-M330 I I

PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS AND LTCH PPS AND IPF PPS SUBPROVIDER 1

1	INPATIENT HOSPITAL SERVICES (SEE INSTRUCTIONS)	
1.01	HOSPITAL SPECIFIC AMOUNT (SEE INSTRUCTIONS)	
1.02	ENTER FROM THE PS&R, THE IRF PPS PAYMENT	
1.03	MEDICARE SSI RATIO (IRF PPS ONLY) (SEE INSTR.)	
1.04	INPATIENT REHABILITATION FACILITY LIP PAYMENTS (SEE INSTRUCTIONS)	
1.05	OUTLIER PAYMENTS	
1.06	TOTAL PPS PAYMENTS (SUM OF LINES 1.01, (1.02, 1.04 FOR COLUMNS 1 & 1.01), 1.05 AND 1.42)	
1.07	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)	
1.08	INPATIENT PSYCHIATRIC FACILITY (IPF) NET FEDERAL IPF PPS PAYMENTS (EXCLUDING OUTLIER, ECT, STOP-LOSS, AND MEDICAL EDUCATION PAYMENTS)	47,217
1.09	NET IPF PPS OUTLIER PAYMENTS	
1.10	NET IPF PPS ECT PAYMENTS	
1.11	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR LATEST COST REPORT FILED PRIOR TO NOVEMBER 15, 2004 (SEE INSTRUCTIONS)	
1.12	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)	
1.13	CURRENT YEARS UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.14	CURRENT YEARS UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.15	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.16	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	6.391781
1.17	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{(1 + ((1.15/1.16)))\}$ RAISED TO THE POWER OF .5150 - 1}	
1.18	MEDICAL EDUCATION ADJUSTMENT (LINE 1.08 MULTIPLIED BY LINE 1.17).	
1.19	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1.08, 1.09, 1.10 AND 1.18)	47,217
1.20	STOP LOSS PAYMENT FLOOR (LINE 1 x 70%)	
1.21	ADJUSTED NET PAYMENT FLOOR (LINE 1.20 x THE APPROPRIATE FEDERAL BLEND PERCENTAGE)	
1.22	STOP LOSS ADJUSTMENT (IF LINE 1.21 IS GREATER THAN LINE 1.19 ENTER THE AMOUNT ON LINE 1.21 LESS LINE 1.19 OTHERWISE ENTER -0-)	
1.23	TOTAL IPF PPS PAYMENTS (SUM OF LINES 1.01, 1.19 AND 1.22)	47,217
1.35	INPATIENT REHABILITATION FACILITY (IRF) UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR COST REPORT PERIODS ENDING ON/OR PRIOR TO NOVEMBER 15, 2004. (SEE INST.)	
1.36	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)	
1.37	CURRENT YEAR'S UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.38	CURRENT YEAR'S UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.39	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.40	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	
1.41	MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.42	MEDICAL EDUCATION ADJUSTMENT (LINE 1.02 MULTIPLIED BY LINE 1.41).	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL (SEE INSTRUCTIONS)	47,217
5	PRIMARY PAYER PAYMENTS	
6	SUBTOTAL	47,217
7	DEDUCTIBLES	5,500
8	SUBTOTAL	41,717
9	COINSURANCE	
10	SUBTOTAL	41,717
11	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROF SERV)	
11.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
11.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
12	SUBTOTAL	41,717
13	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
13.01	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)	
14	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
15	OTHER ADJUSTMENTS (SPECIFY)	
15.99	OUTLIER RECONCILIATION ADJUSTMENT	
16	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/27/2011
I	15-1330	I	FROM 1/ 1/2010	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 12/31/2010	I	PART I
I	15-M330	I		I	

PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS AND LTCH PPS AND IPF PPS  
SUBPROVIDER 1

	RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
17	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	41,717
18	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
19	INTERIM PAYMENTS	41,717
19.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
20	BALANCE DUE PROVIDER/PROGRAM	
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

----- FI ONLY -----

50	ORIGINAL PPS AMOUNT OR ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS).
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS).

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET E-3  
 I COMPONENT NO: I TO 12/31/2010 I PART II  
 I 15-1330 I I

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	5,448,365
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	5,448,365
5	PRIMARY PAYER PAYMENTS	1
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	5,502,848

COMPUTATION OF LESSER OF COST OR CHARGES

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

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	5,502,848
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	599,500
21	EXCESS REASONABLE COST	
22	SUBTOTAL	4,903,348
23	COINSURANCE	7,425
24	SUBTOTAL	4,895,923
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	8,113
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	8,113
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	8,113
26	SUBTOTAL	4,904,036
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	4,904,036
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	5,684,075
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	-780,039
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET E-3  
 I COMPONENT NO: I TO 12/31/2010 I PART III  
 I 15-5316 I I

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/27/2011
I	15-1330	I	FROM 1/ 1/2010	I	WORKSHEET	E-3
I	COMPONENT NO:	I	TO 12/31/2010	I	PART III	
I	15-5316	I		I		

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

TITLE XVIII

SNF

PPS  
TITLE V OR  
TITLE XIX  
1

TITLE XVIII  
SNF PPS  
2

59 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)  
IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	983,608			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	6,102,609			
5	OTHER RECEIVABLES				
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7	INVENTORY	700,080			
8	PREPAID EXPENSES	499,162			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS	14,939,754			
11	TOTAL CURRENT ASSETS	23,225,213			
FIXED ASSETS					
12	LAND	358,667			
12.01	LAND IMPROVEMENTS	1,206,356			
13	LAND IMPROVEMENTS	1,206,356			
13.01	LESS ACCUMULATED DEPRECIATION	-761,392			
14	BUILDINGS	33,344,312			
14.01	LESS ACCUMULATED DEPRECIATION	-9,330,294			
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT	4,278,072			
16.01	LESS ACCUMULATED DEPRECIATION	-1,177,456			
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT	17,681,229			
18.01	LESS ACCUMULATED DEPRECIATION	-12,980,366			
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	32,619,128			
OTHER ASSETS					
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	11,863,529			
26	TOTAL OTHER ASSETS	11,863,529			
27	TOTAL ASSETS	67,707,870			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
<b>LIABILITIES AND FUND BALANCE</b>				
<b>CURRENT LIABILITIES</b>				
28	ACCOUNTS PAYABLE			
	1,111,278			
29	SALARIES, WAGES & FEES PAYABLE			
	995,196			
30	PAYROLL TAXES PAYABLE			
31	NOTES AND LOANS PAYABLE (SHORT TERM)			
32	DEFERRED INCOME			
33	ACCELERATED PAYMENTS			
34	DUE TO OTHER FUNDS			
	1,008,077			
35	OTHER CURRENT LIABILITIES			
	3,108,616			
36	TOTAL CURRENT LIABILITIES			
	6,223,167			
<b>LONG TERM LIABILITIES</b>				
37	MORTGAGE PAYABLE			
	35,312,240			
38	NOTES PAYABLE			
	1,835,862			
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			
	37,148,102			
43	TOTAL LIABILITIES			
	43,371,269			
<b>CAPITAL ACCOUNTS</b>				
44	GENERAL FUND BALANCE			
	24,336,601			
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			
	24,336,601			
52	TOTAL LIABILITIES AND FUND BALANCES			
	67,707,870			

STATEMENT OF CHANGES IN FUND BALANCES

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	FUND BALANCE AT BEGINNING		27,451,688		
	OF PERIOD				
2	NET INCOME (LOSS)		-1,866,601		
3	TOTAL		25,585,087		
4	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5	ADDITIONS (CREDIT ADJUSTM				
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL		25,585,087		
12	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
	PY ADJUSTMENTS TO POP		29,269		
13	PY ADJUSTMENTS TO HOSPITA	1,219,217			
14					
15					
16					
17					
18	TOTAL DEDUCTIONS		1,248,486		
19	FUND BALANCE AT END OF		24,336,601		
	PERIOD PER BALANCE SHEET				

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET G-2  
 I I TO 12/31/2010 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	6,413,828		6,413,828
2 00 SUBPROVIDER	3,252,776		3,252,776
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
6 00 SKILLED NURSING FACILITY	1,896,045		1,896,045
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	11,562,649		11,562,649
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT	2,200,608		2,200,608
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	2,200,608		2,200,608
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	13,763,257		13,763,257
17 00 ANCILLARY SERVICES	21,587,365	54,890,505	76,477,870
18 00 OUTPATIENT SERVICES		1,144,782	1,144,782
19 00 HOME HEALTH AGENCY		707,255	707,255
20 00 AMBULANCE SERVICES			
22 00 AMBULATORY SURGICAL CENTER (D.P.)			
23 00 HOSPICE			
24 00 PHYSICIAN OFFICES		1,466,853	1,466,853
25 00 TOTAL PATIENT REVENUES	35,350,622	58,209,395	93,560,017

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		43,579,958	
ADD (SPECIFY)			
27 00 INSTITUTIONAL PHARMACY	2,201,900		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		2,201,900	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		45,781,858	

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: 15-1330 I PERIOD: FROM 1/ 1/2010 I TO 12/31/2010 I PREPARED 5/27/2011 I WORKSHEET G-3

DESCRIPTION

1	TOTAL PATIENT REVENUES	93,560,017
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	54,679,098
3	NET PATIENT REVENUES	38,880,919
4	LESS: TOTAL OPERATING EXPENSES	45,781,858
5	NET INCOME FROM SERVICE TO PATIENTS	-6,900,939
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	12,424
7	INCOME FROM INVESTMENTS	169,124
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	389,455
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	97,691
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	22,889
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	154,337
23	GOVERNMENTAL APPROPRIATIONS	431,605
24	TRANSPORTATION	2,420
24.01	LIFELINE	34,404
24.02	OB RENTALS	789
24.03	WORTHMAN FITNESS CENTER	83,922
24.04	CREDIT MONEY	1,287,381
24.05	GRANT REVENUE	485,909
24.06	MISC INCOME	4,367
24.07	INSTITUTIONAL PHARMACY	1,857,621
25	TOTAL OTHER INCOME	5,034,338
26	TOTAL	-1,866,601
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	-1,866,601

HHA 1

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPORTATION 3	CONTRACTED/ PURCHASED SVCS 4	OTHER COSTS 5	TOTAL 6
GENERAL SERVICE COST CENTERS						
1						
2						
3						
4						
5						
5	201,383				65,171	266,554
HHA REIMBURSABLE SERVICES						
6	385,740					385,740
7						
8						
9						
10						
11	35,749					35,749
12						
13						
13.20						
14						
HHA NONREIMBURSABLE SERVICES						
15						
16						
17						
18						
19						
20						
21						
22						
23						
23.50						
24	622,872				65,171	688,043
24	TOTAL (SUM OF LINES 1-23)					

	RECLASSIFI- CATIONS 7	RECLASSIFIED TRIAL BALANCE 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION 10
GENERAL SERVICE COST CENTERS				
1				
2				
3				
4				
5		266,554		266,554
HHA REIMBURSABLE SERVICES				
6		385,740		385,740
7				
8				
9				
10				
11		35,749		35,749
12				
13				
13.20				
14				
HHA NONREIMBURSABLE SERVICES				
15				
16				
17				
18				
19				
20				
21				
22				
23				
23.50				
24		688,043		688,043
24	TOTAL (SUM OF LINES 1-23)			

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
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	NET EXPENSES FOR COST ALLOCATION	CAP-REL COST-BLDG & FIX	CAP-REL COST-MOV EQUIP	PLANT OPER & MAINT	TRANSPORTATIO N	SUBTOTAL	ADMINISTRATIV E & GENERAL
	0	1	2	3	4	4A	5
GENERAL SERVICE COST CENTERS							
1							
2							
3							
4							
5							
5	ADMINISTRATIVE & GENERAL	266,554				266,554	266,554
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	385,740				385,740	243,946
7	PHYSICAL THERAPY						
8	OCCUPATIONAL THERAPY						
9	SPEECH PATHOLOGY						
10	MEDICAL SOCIAL SERVICES						
11	HOME HEALTH AIDE	35,749				35,749	22,608
12	SUPPLIES						
13	DRUGS						
13.20	COST ADMINISTERING DRUGS						
14	DME						
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SVCS						
16	RESPIRATORY THERAPY						
17	PRIVATE DUTY NURSING						
18	CLINIC						
19	HEALTH PROM ACTIVITIES						
20	DAY CARE PROGRAM						
21	HOME DEL MEALS PROGRAM						
22	HOMEMAKER SERVICE						
23	ALL OTHERS						
23.50	TELEMEDICINE						
24	TOTAL (SUM OF LINES 1-23)	688,043				688,043	

TOTAL

6

GENERAL SERVICE COST CENTERS							
1	CAP-REL COST-BLDG & FIX						
2	CAP-REL COST-MOV EQUIP						
3	PLANT OPER & MAINT						
4	TRANSPORTATION						
5	ADMINISTRATIVE & GENERAL						
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	629,686					
7	PHYSICAL THERAPY						
8	OCCUPATIONAL THERAPY						
9	SPEECH PATHOLOGY						
10	MEDICAL SOCIAL SERVICES						
11	HOME HEALTH AIDE	58,357					
12	SUPPLIES						
13	DRUGS						
13.20	COST ADMINISTERING DRUGS						
14	DME						
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SVCS						
16	RESPIRATORY THERAPY						
17	PRIVATE DUTY NURSING						
18	CLINIC						
19	HEALTH PROM ACTIVITIES						
20	DAY CARE PROGRAM						
21	HOME DEL MEALS PROGRAM						
22	HOMEMAKER SERVICE						
23	ALL OTHERS						
23.50	TELEMEDICINE						
24	TOTAL (SUM OF LINES 1-23)	688,043					

HHA 1

	CAP-REL COST-BLDG & FIX ( SQUARE FEET )	CAP-REL COST-MOV EQUIP ( DOLLAR VALUE )	PLANT OPER & MAINT ( SQUARE FEET )	TRANSPORTATIO N ( MILEAGE )	RECONCILIATIO N (	ADMINISTRATIV E & GENERAL ( ACCUM. COST )
	1	2	3	4	5A	5
GENERAL SERVICE COST CENTERS						
1	CAP-REL COST-BLDG & FIX					
2	CAP-REL COST-MOV EQUIP					
3	PLANT OPER & MAINT					
4	TRANSPORTATION					
5	ADMINISTRATIVE & GENERAL					
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE					421,489
7	PHYSICAL THERAPY					
8	OCCUPATIONAL THERAPY					
9	SPEECH PATHOLOGY					
10	MEDICAL SOCIAL SERVICES					
11	HOME HEALTH AIDE					35,749
12	SUPPLIES					
13	DRUGS					
13.20	COST ADMINISTERING DRUGS					
14	DME					
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SVCS					
16	RESPIRATORY THERAPY					
17	PRIVATE DUTY NURSING					
18	CLINIC					
19	HEALTH PROM ACTIVITIES					
20	DAY CARE PROGRAM					
21	HOME DEL MEALS PROGRAM					
22	HOMEMAKER SERVICE					
23	ALL OTHERS					
23.50	TELEMEDICINE					
24	TOTAL (SUM OF LINES 1-23)				-266,554	421,489
25	COST TO BE ALLOCATED					266,554
26	UNIT COST MULTIPLIER					.632410

HHA 1

HHA COST CENTER	HHA TRIAL BALANCE (1) 0	NEW CAP REL COSTS-BLDG & 3	NEW CAP REL COSTS-MVBLE 4	NEW CAP REL COSTS-RENTAL 4.01	EMPLOYEE BEN EFITS 5	SUBTOTAL 5A
1 ADMIN & GENERAL				161,521	218,748	380,269
2 SKILLED NURSING CARE	629,686					629,686
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE	58,357					58,357
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	688,043			161,521	218,748	1,068,312
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.  
 (2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA COST CENTER	ADMINISTRATI VE & GENERAL 6	OPERATION OF PLANT 8	BIO-MEDICAL 8.01	UTILITIES - HOSPITAL 8.02	UTILITIES - OFFSITE BLDG 8.03	LAUNDRY & LI NEN SERVICE 9
1 ADMIN & GENERAL	67,016	167,889	92			
2 SKILLED NURSING CARE	110,972					
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE	10,284					
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	188,272	167,889	92			
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.  
 (2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA 1

HHA COST CENTER	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPL	PHARMACY
	10	11	12	14	15	16
1 ADMIN & GENERAL	77,561					
2 SKILLED NURSING CARE						
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	77,561					
21 UNIT COST MULTIPLIER						

- (1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
- (2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA COST CENTER	MEDICAL RECORDS & LIBRAR	SUBTOTAL	POST STEP DOWN ADJUST	SUBTOTAL	ALLOCATED HHA A & G	TOTAL HHA COSTS
	17	25	26	27	28	29
1 ADMIN & GENERAL		692,827		692,827		
2 SKILLED NURSING CARE		740,658		740,658	634,065	1,374,723
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE		68,641		68,641	58,762	127,403
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)		1,502,126		1,502,126	692,827	1,502,126
21 UNIT COST MULTIPLIER					0.856083	

- (1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
- (2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA 1

HHA COST CENTER	NEW CAP REL COSTS-BLDG & (SQUARE FEET	NEW CAP REL COSTS-MVBLE (DOLLAR VALUE	NEW CAP REL COSTS-RENTAL (SQUARE FEET	EMPLOYEE BEN EFITS (GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ( ACCUM. COST
	3	4	4.01	5	6A	6
1 ADMIN & GENERAL			10,928	622,872		380,269
2 SKILLED NURSING CARE						629,686
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						58,357
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)			10,928	622,872		1,068,312
21 COST TO BE ALLOCATED			161,521	218,748		188,272
22 UNIT COST MULTIPLIER			14.780472	0.351193		0.176233

HHA COST CENTER	OPERATION OF PLANT (SQUARE FEET	BIO-MEDICAL (COST	UTILITIES - HOSPITAL (SQUARE FEET	UTILITIES - OFFSITE BLDG (COSTS	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY	HOUSEKEEPING (SQUARE FEET
	8	8.01	8.02	8.03	9	10
1 ADMIN & GENERAL	10,928	6,261				10,928
2 SKILLED NURSING CARE						
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)	10,928	6,261				10,928
21 COST TO BE ALLOCATED	167,889	92				77,561
22 UNIT COST MULTIPLIER	15.363195	0.014694				7.097456

HHA 1

HHA COST CENTER	DIETARY (MEALS ERVED	CAFETERIA S (HOURS )	NURSING ADMI NISTRATION (DIRECT ) SING HRS	CENTRAL SERV ICES & SUPPL (COSTED ) EQUIS.	PHARMACY (COSTED ) EQUIS.	MEDICAL RECO RDS & LIBRAR (TIME ) SPENT
	11	12	14	15	16	17
1 ADMIN & GENERAL						
2 SKILLED NURSING CARE						
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)						
21 COST TO BE ALLOCATED						
22 UNIT COST MULIPLIER						

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET H-6  
 I HHA NO: I TO 12/31/2010 I PARTS I II & III  
 I 15-7172 I HHA 1

[ ] TITLE V [X] TITLE XVIII [ ] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:  
 COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

COST PER VISIT COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	PROGRAM VISITS PART A
PATIENT SERVICES							
1 SKILLED NURSING	2	1,374,723	2	1,374,723	3,617	380.07	1,130
2 PHYSICAL THERAPY	3				848		232
3 OCCUPATIONAL THERAPY	4				129		37
4 SPEECH PATHOLOGY	5				96		40
5 MEDICAL SOCIAL SERVICES	6						
6 HOME HEALTH AIDE SERVICE	7	127,403		127,403	3,202	39.79	193
7 TOTAL		1,502,126		1,502,126	7,892		1,632

	-----PROGRAM VISITS-----		-----COST OF SERVICES-----		TOTAL PROGRAM COST
	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	
	7	8	PART A 9	10	11
1 SKILLED NURSING	683		429,479	259,588	689,067
2 PHYSICAL THERAPY	202				
3 OCCUPATIONAL THERAPY	23				
4 SPEECH PATHOLOGY	35				
5 MEDICAL SOCIAL SERVICES					
6 HOME HEALTH AIDE SERVICES	532		7,679	21,168	28,847
7 TOTAL	1,475		437,158	280,756	717,914

LIMITATION COST COMPUTATION					PROGRAM COST LIMITS	PROGRAM VISITS
PATIENT SERVICES	1	2	3	4	5	PART A 6
8 SKILLED NURSING						
8.01 SKILLED NURSING						
9 PHYSICAL THERAPY						
9.01 PHYSICAL THERAPY						
10 OCCUPATIONAL THERAPY						
10.01 OCCUPATIONAL THERAPY						
11 SPEECH PATHOLOGY						
11.01 SPEECH PATHOLOGY						
12 MEDICAL SOCIAL SERVICES						
12.01 MEDICAL SOCIAL SERVICES						
13 HOME HEALTH AIDE SERVICE						
13.01 HOME HEALTH AIDE SERVICE						
14 TOTAL						

	-----PROGRAM VISITS-----		-----COST OF SERVICES-----		TOTAL PROGRAM COST
	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	
	7	8	PART A 9	10	11
8 SKILLED NURSING					
8.01 SKILLED NURSING					
9 PHYSICAL THERAPY					
9.01 PHYSICAL THERAPY					
10 OCCUPATIONAL THERAPY					
10.01 OCCUPATIONAL THERAPY					
11 SPEECH PATHOLOGY					
11.01 SPEECH PATHOLOGY					
12 MEDICAL SOCIAL SERVICES					
12.01 MEDICAL SOCIAL SERVICES					
13 HOME HEALTH AIDE SERVICE					
13.01 HOME HEALTH AIDE SERVICE					
14 TOTAL					12

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 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET H-6  
 I HHA NO: I TO 12/31/2010 I PARTS I II & III  
 I 15-7172 I HHA 1

[ ] TITLE V [X] TITLE XVIII [ ] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:  
 COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

SUPPLIES AND EQUIPMENT COST COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I) 1	SHARED ANCILLARY COSTS (FROM PART II) 2	TOTAL HHA COSTS 3	TOTAL CHARGES 4	RATIO 5	PROGRAM COVERED CHARGES PART A 6
15 COST OF MEDICAL SUPPLIES	8.00				8,540		5,970
16 COST OF DRUGS	9.00						
16.20 COST OF DRUGS	9.20						

	PROGRAM COVERED CHARGES PART B		COST OF SERVICES PART B	
	NOT SUBJECT TO DEDUCT & COINSUR 7	SUBJECT TO DEDUCT & COINSUR 8	NOT SUBJECT TO DEDUCT & COINSUR 9	SUBJECT TO DEDUCT & COINSUR 11
15 COST OF MEDICAL SUPPLIES	2,570			
16 COST OF DRUGS				
16.20 COST OF DRUGS				

PER BENEFICIARY COST LIMITATION:	MSA NUMBER 1	AMOUNT 2
162 PROGRAM UNDUP CENSUS FROM WRKST S-4		
16.01 PROGRAM UNDUP CENSUS FROM WRKST S-4		
17 PER BENE COST LIMITATION (FRM FI)		
17.01 PER BENE COST LIMITATION (FRM FI)		
18 PER BENE COST LIMITATION (LN 17*18)		

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

	FROM WKST C PT I, COL 9	COST TO CHARGE RATIO 1	TOTAL HHA CHARGES 2	HHA SHARED ANCILLARY COSTS 3	TRANSFER TO PART I AS INDICATED 4
1 PHYSICAL THERAPY	50	.759197			COL 2, LN 2
2 OCCUPATIONAL THERAPY	51	.525566			COL 2, LN 3
3 SPEECH PATHOLOGY	52	.426202			COL 2, LN 4
4 MEDICAL SUPPLIES CHARGED TO PATIENT	55	.274870			COL 2, LN 15
4.30 IMPL. DEV. CHARGED TO PATIENT	55.30	.421847			
5 DRUGS CHARGED TO PATIENTS	56	.258001			COL 2, LN 16

PART III - OUTPATIENT THERAPY REDUCTION COMPUTATION

	FROM PART I, COL 5	COST PER VISIT 2	PART B SERVICES SUBJECT TO DEDUCTIBLES AND COINSURANCE		PROGRAM COSTS 4	PROG VISITS ON OR AFTER 5
			PRIOR 1/1/1998 TO 12/31/1998 3	PRIOR 1/1/1998 TO 12/31/1998 4		
1 PHYSICAL THERAPY	1	2	2.01	3	3.01	5
2 OCCUPATIONAL THERAPY		3				
3 SPEECH PATHOLOGY		4				
4 TOTAL (SUM OF LINES 1-3)						

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2011  
 I 15-1330 I FROM 1/ 1/2010 I WORKSHEET H-7  
 I HHA NO: I TO 12/31/2010 I PARTS I & II  
 I 15-7172 I I

TITLE XVIII

HHA 1

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

PART B NOT SUBJECT TO DED & COINS 2  
 PART B SUBJECT TO DED & COINS 3

- 1 REASONABLE COST OF SERVICES
- 2 TOTAL CHARGES
- 3 CUSTOMARY CHARGES
- 4 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS
- 5 AMOUNT 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(B)
- 6 RATIO OF LINE 3 TO 4 (NOT TO EXCEED 1.000000)
- 7 TOTAL CUSTOMARY CHARGES
- 8 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST
- 9 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES
- 10 PRIMARY PAYOR AMOUNTS

1

2

3

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

PART A SERVICES 1  
 PART B SERVICES 2

- 10 TOTAL REASONABLE COST
- 10.01 TOTAL PPS REIMBURSEMENT-FULL EPISODES WITHOUT OUTLIERS 253,530 195,305
- 10.02 TOTAL PPS REIMBURSEMENT-FULL EPISODES WITH OUTLIERS 2,050
- 10.03 TOTAL PPS REIMBURSEMENT-LUPA EPISODES 4,608 1,536
- 10.04 TOTAL PPS REIMBURSEMENT-PEP EPISODES 4,038 1,333
- 10.05 TOTAL PPS REIMBURSEMENT-SCIC WITHIN A PEP EPISODE
- 10.06 TOTAL PPS REIMBURSEMENT-SCIC EPISODES
- 10.07 TOTAL PPS OUTLIER REIMBURSEMENT-FULL EPISODES WITH OUTLIERS 2,595
- 10.08 TOTAL PPS OUTLIER REIMBURSEMENT-PEP EPISODES
- 10.09 TOTAL PPS OUTLIER REIMBURSEMENT-SCIC WITHIN A PEP EPISODE
- 10.10 TOTAL PPS OUTLIER REIMBURSEMENT-SCIC EPISODES
- 10.11 TOTAL OTHER PAYMENTS
- 10.12 DME PAYMENTS
- 10.13 OXYGEN PAYMENTS
- 10.14 PROSTHETIC AND ORTHOTIC PAYMENTS
- 11 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)
- 12 SUBTOTAL 266,821 198,174
- 13 EXCESS REASONABLE COST
- 14 SUBTOTAL 266,821 198,174
- 15 COINSURANCE BILLED TO PROGRAM PATIENTS
- 16 NET COST 266,821 198,174
- 17 REIMBURSABLE BAD DEBTS
- 17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)
- 18 TOTAL COSTS - CURRENT COST REPORTING PERIOD 266,821 198,174
- 19 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS
- 20 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR DECREASE IN MEDICARE UTILIZATION
- 21 OTHER ADJUSTMENTS (SPECIFY)
- 22 SUBTOTAL 266,821 198,174
- 23 SEQUESTRATION ADJUSTMENT
- 24 SUBTOTAL 266,821 198,174
- 25 INTERIM PAYMENTS 266,821 198,174
- 25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)
- 26 BALANCE DUE PROVIDER/PROGRAM
- 27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II SECTION 115.2

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

I PROVIDER NO: 15-1330  
 I HHA NO: 15-7172  
 I PERIOD: FROM 1/1/2010 TO 12/31/2010  
 I PREPARED 5/27/2011  
 I WORKSHEET H-8

TITLE XVIII HHA 1

DESCRIPTION	P A R T 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		266,821		198,174
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER	.01			
ADJUSTMENTS TO PROVIDER	.02			
ADJUSTMENTS TO PROVIDER	.03			
ADJUSTMENTS TO PROVIDER	.04			
ADJUSTMENTS TO PROVIDER	.05			
ADJUSTMENTS TO PROVIDER	.49			
ADJUSTMENTS TO PROGRAM	.50			
ADJUSTMENTS TO PROGRAM	.51			
ADJUSTMENTS TO PROGRAM	.52			
ADJUSTMENTS TO PROGRAM	.53			
ADJUSTMENTS TO PROGRAM	.54			
ADJUSTMENTS TO PROGRAM	.99			
SUBTOTAL		NONE		NONE
4 TOTAL INTERIM PAYMENTS		266,821		198,174
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			
7 TOTAL MEDICARE PROGRAM LIABILITY		266,821		198,174

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 CAPITAL PAYMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/27/2011
I	15-1330	I	FROM 1/ 1/2010	I	WORKSHEET L	
I	COMPONENT NO:	I	TO 12/31/2010	I	PARTS I-IV	
I	15-1330	I		I		

TITLE XIX

HOSPITAL

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS	
	CAPITAL FEDERAL AMOUNT	
2	CAPITAL DRG OTHER THAN OUTLIER	
3	CAPITAL DRG OUTLIER PAYMENTS PRIOR TO 10/01/1997	
3 .01	CAPITAL DRG OUTLIER PAYMENTS AFTER 10/01/1997	
	INDIRECT MEDICAL EDUCATION ADJUSTMENT	
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS	.00
	IN THE COST REPORTING PERIOD	
4 .01	NUMBER OF INTERNS AND RESIDENTS	.00
	(SEE INSTRUCTIONS)	
4 .02	INDIRECT MEDICAL EDUCATION PERCENTAGE	.00
4 .03	INDIRECT MEDICAL EDUCATION ADJUSTMENT	
	(SEE INSTRUCTIONS)	
5	PERCENTAGE OF SSI RECEIPT PATIENT DAYS TO	.00
	MEDICARE PART A PATIENT DAYS	
5 .01	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL	.00
	DAYS REPORTED ON 5-3, PART I	
5 .02	SUM OF 5 AND 5.01	.00
5 .03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE	.00
5 .04	DISPROPORTIONATE SHARE ADJUSTMENT	
6	TOTAL PROSPECTIVE CAPITAL PAYMENTS	
PART II - HOLD HARMLESS METHOD		
1	NEW CAPITAL	
2	OLD CAPITAL	
3	TOTAL CAPITAL	
4	RATIO OF NEW CAPITAL TO OLD CAPITAL	.000000
5	TOTAL CAPITAL PAYMENTS UNDER 100% FEDERAL RATE	
6	REDUCTION FACTOR FOR HOLD HARMLESS PAYMENT	
7	REDUCED OLD CAPITAL AMOUNT	
8	HOLD HARMLESS PAYMENT FOR NEW CAPITAL	
9	SUBTOTAL	
10	PAYMENT UNDER HOLD HARMLESS	
PART III - PAYMENT UNDER REASONABLE COST		
1	PROGRAM INPATIENT ROUTINE CAPITAL COST	
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST	
3	TOTAL INPATIENT PROGRAM CAPITAL COST	
4	CAPITAL COST PAYMENT FACTOR	
5	TOTAL INPATIENT PROGRAM CAPITAL COST	
PART IV - COMPUTATION OF EXCEPTION PAYMENTS		
1	PROGRAM INPATIENT CAPITAL COSTS	
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY	
	CIRCUMSTANCES	
3	NET PROGRAM INPATIENT CAPITAL COSTS	
4	APPLICABLE EXCEPTION PERCENTAGE	.00
5	CAPITAL COST FOR COMPARISON TO PAYMENTS	
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY	.00
	CIRCUMSTANCES	
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL	
	FOR EXTRAORDINARY CIRCUMSTANCES	
8	CAPITAL MINIMUM PAYMENT LEVEL	
9	CURRENT YEAR CAPITAL PAYMENTS	
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT	
	LEVEL TO CAPITAL PAYMENTS	
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT	
	LEVEL OVER CAPITAL PAYMENT	
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL	
	TO CAPITAL PAYMENTS	
13	CURRENT YEAR EXCEPTION PAYMENT	
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT	
	LEVEL OVER CAPITAL PAYMENT FOR FOLLOWING PERIOD	
15	CUR YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT	
16	CURRENT YEAR OPERATING AND CAPITAL COSTS	
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT	
	(SEE INSTRUCTIONS)	