

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	14-1327	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: 5/16/2011 TIME 16:50

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:

WABASH GENERAL HOSPITAL 14-1327

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

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

\_\_\_\_\_  
 TITLE

\_\_\_\_\_  
 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2		3	4	
1	HOSPITAL	0	498,570	143,127	0	0
3	SWING BED - SNF	0	83,981	0	0	0
9	RHC	0	0	-124	0	0
100	TOTAL	0	582,551	143,003	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS  
 1 STREET: 1418 COLLEGE DRIVE P.O. BOX:  
 1.01 CITY: MT. CARMEL STATE: IL ZIP CODE: 62863- COUNTY: WABASH

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;				PAYMENT SYSTEM (P,T,O OR N)			
COMPONENT 0	COMPONENT NAME 1	PROVIDER NO. 2	NPI NUMBER 2.01	DATE CERTIFIED 3	V 4	XVIII 5	XIX 6
02.00	HOSPITAL	14-1327		6/ 1/2003	N	O	N
04.00	SWING BED - SNF	14-2327		6/ 1/2003	N	O	N
14.00	HOSPITAL-BASED RHC	14-8501		4/ 1/2009	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2010 TO: 12/31/2010  
 18 TYPE OF CONTROL 1 2

TYPE OF HOSPITAL/SUBPROVIDER  
 19 HOSPITAL 1  
 20 SUBPROVIDER

OTHER INFORMATION

- 21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.
- 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. N
- 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
- 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 N Y 14999
- 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 N  
 PAYMENTS FOR I&R?

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 N  
 DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.

25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N  
 25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED  
 UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES OR "N" FOR  
 NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)

25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE N  
 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 OCCURING IN ALL NON-PROVIDER SETTINGS. 0.00

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

25.09 0000 0.00  
 26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT  
 IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01.  
 SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0

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

27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913  
 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 6/ 1/2003

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

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

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

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

28.03 STAFFING % Y/N  
 28.04 RECRUITMENT 1.00% Y  
 28.05 RETENTION 0.00%  
 28.06 TRAINING 0.00%  
 0.00%

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

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

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). Y

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)?

V XVIII XIX

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

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

TITLE XIX INPATIENT SERVICES

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

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

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

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

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

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

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

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

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

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

58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). 0

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

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

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

MULTICAMPUS

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

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

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00

SETTLEMENT DATA

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

MISCELLANEOUS DATA

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

COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	I/P DAYS / TITLE XVIII	O/P VISITS / NOT LTCH N/A	TRIPS / TITLE XIX
1 ADULTS & PEDIATRICS	21	7,665	60,408.00	3	4	1,973	94
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF						317	
4 ADULTS & PED-SB NF							72
5 TOTAL ADULTS AND PEDS	21	7,665	60,408.00			2,290	166
6 INTENSIVE CARE UNIT	4	1,460	2,448.00			45	6
12 TOTAL	25	9,125	62,856.00			2,335	172
13 RPCH VISITS							
24 RURAL HEALTH CLINIC						284	
25 TOTAL	25						
26 OBSERVATION BED DAYS							55
27 AMBULANCE TRIPS						637	
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	TITLE XIX ADMITTED	OBSERVATION NOT ADMITTED	BEDS	O/P VISITS TOTAL ALL PATS	TRIPS ADMITTED	OBSERVATION NOT ADMITTED	INTERNS & RES. TOTAL	RES. FTES LESS I&R NON-PHYS ANES
1 ADULTS & PEDIATRICS	5.01	5.02		6	6.01	6.02	7	8
2 HMO				2,540				
2 01 HMO - (IRF PPS SUBPROVIDER)								
3 ADULTS & PED-SB SNF				317				
4 ADULTS & PED-SB NF				72				
5 TOTAL ADULTS AND PEDS				2,929				
6 INTENSIVE CARE UNIT				97				
12 TOTAL				3,026				
13 RPCH VISITS								
24 RURAL HEALTH CLINIC				4,814				
25 TOTAL								
26 OBSERVATION BED DAYS				682				
27 AMBULANCE TRIPS								
28 EMPLOYEE DISCOUNT DAYS								
28 01 EMP DISCOUNT DAYS -IRF								
29 LABOR & DELIVERY DAYS								

COMPONENT	I & R FTES NET	EMPLOYEES ON PAYROLL	FULL TIME EQUIV NONPAID WORKERS	TITLE V	DISCHARGES TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2 HMO					514	37	722
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							
12 TOTAL		189.64			514	37	722
13 RPCH VISITS							
24 RURAL HEALTH CLINIC		2.08					
25 TOTAL		191.72					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 1418 COLLEGE DRIVE  
 1.01 CITY: MT.CARMEL STATE: IL ZIP CODE: 62863 COUNTY: WABASH  
 2 DESIGNATION (FOR FQHCS ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN R

SOURCE OF FEDERAL FUNDS:

	GRANT AWARD	DATE
3 COMMUNITY HEALTH CENTER (SECTION 339(d), PHS ACT)	1	2 / /
4 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/ /
5 HEALTH SERVICES FOR THE HOMELESS (SECTION 340(d), PHS ACT)		/ /
6 APPALACHIAN REGIONAL COMMISSION		/ /
7 LOOK-ALIKES		/ /
8 OTHER (SPECIFY)		/ /

PHYSICIAN INFORMATION:

	PHYSICIAN NAME	BILLING NUMBER
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT		

	PHYSICIAN NAME	HOURS OF SUPERVISION
10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD		

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS.) N

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12 CLINIC	1200	2100	1800	2100	1800	2100	1800	2100	1800	2100	1800	2100	1200	2100

(1) ENTER CLINIC HOURS OF OPERATIONS ON SUBSCRIPTS OF LINE 12 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? N

14 IS THIS A CONSOLIDATED COST REPORT DEFINED IN THE RURAL HEALTH CLINIC MANUAL? IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS INCLUDED IN THIS REPORT, COMPLETE LINE 15 AND COMPLETE ONLY ONE WORKSHEET SERIES M FOR THE CONSOLIDATED GROUP. IF NO, COMPLETE A SEPARATE WORKSHEET S-8 FOR EACH COMPONENT ACCOMPANIED BY A CORRESPONDING WORKSHEET M SERIES. N

15 PROVIDER NAME: PROVIDER NUMBER:

	TITLE V	TITLE XVIII	TITLE XIX
16 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS & RESIDENTS.	N		

17 HAS THE HOSPITALS' BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? IF YES, SEE INSTRUCTIONS. N

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 153,539
17.01	GROSS MEDICAID REVENUES 3,307,398
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)
20	RESTRICTED GRANTS
21	NON-RESTRICTED GRANTS
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES 3,460,937
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) .421522
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS
27	TOTAL SCHIP COST, (LINE 24 * LINE 26)
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS 3,307,398

HOSPITAL UNCOMPENSATED CARE DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
I 14-1327 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)	1,394,141
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29)	1,394,141

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:  
I 14-1327  
I

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

I PREPARED 5/16/2011  
I WORKSHEET A  
I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		423,781	423,781		423,781
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		602,385	602,385	648,355	1,250,740
5	0500 EMPLOYEE BENEFITS	129,747	3,528,857	3,658,604		3,658,604
6	0600 ADMINISTRATIVE & GENERAL	853,853	2,139,770	2,993,623	50,447	3,044,070
8	0800 OPERATION OF PLANT	140,324	623,677	764,001	30,666	794,667
10	1000 HOUSEKEEPING	231,553	48,772	280,325		280,325
11	1100 DIETARY	275,864	203,445	479,309	-316,755	162,554
12	1200 CAFETERIA				315,665	315,665
14	1400 NURSING ADMINISTRATION	140,716	8,854	149,570		149,570
17	1700 MEDICAL RECORDS & LIBRARY	266,045	36,726	302,771	-5,068	297,703
18	1800 SOCIAL SERVICE	101,389	7,989	109,378		109,378
20	2000 NONPHYSICIAN ANESTHETISTS	583,722	65,873	649,595	-2,268	647,327
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	1,161,119	351,096	1,512,215	-51,497	1,460,718
26	2600 INTENSIVE CARE UNIT	236,852	7,921	244,773	-2,658	242,115
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	569,965	312,035	882,000	-79,176	802,824
40	4000 ANESTHESIOLOGY					
41	4100 RADIOLOGY-DIAGNOSTIC	576,276	865,671	1,441,947	-151,269	1,290,678
44	4400 LABORATORY	669,175	633,859	1,303,034	-65,599	1,237,435
49	4900 RESPIRATORY THERAPY	376,921	170,730	547,651	-18,144	529,507
50	5000 PHYSICAL THERAPY	483,796	33,456	517,252	-1,168	516,084
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	97,791	1,390,164	1,487,955	84,740	1,572,695
55.30	5530 IMPL. DEV. CHARGED TO PATIENT				116,309	116,309
56	5600 DRUGS CHARGED TO PATIENTS	307,387	1,353,770	1,661,157	-4,309	1,656,848
59	3480 ONCOLOGY	180,445	173,636	354,081	-30,121	323,960
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	24,716	1,467	26,183		26,183
61	6100 EMERGENCY	781,200	1,767,194	2,548,394	-46,525	2,501,869
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950 OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310 RURAL HEALTH CLINIC	171,268	6,089	177,357	-1,819	175,538
	OTHER REIMBURS COST CNTRS					
65	6500 AMBULANCE SERVICES	444,857	114,456	559,313	-19,139	540,174
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		327,200	327,200	-327,200	
95	SUBTOTALS	8,804,981	15,198,873	24,003,854	123,467	24,127,321
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800 PHYSICIANS' PRIVATE OFFICES	2,101,352	947,130	3,048,482	-123,467	2,925,015
101	TOTAL	10,906,333	16,146,003	27,052,336	-0-	27,052,336

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I  
I 14-1327 I  
I I

I PERIOD: I PREPARED 5/16/2011  
I FROM 1/ 1/2010 I WORKSHEET A  
I TO 12/31/2010 I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT		423,781
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-87,736	1,163,004
5	0500 EMPLOYEE BENEFITS	87,735	3,746,339
6	0600 ADMINISTRATIVE & GENERAL	-378,711	2,665,359
8	0800 OPERATION OF PLANT		794,667
10	1000 HOUSEKEEPING		280,325
11	1100 DIETARY	-5,927	156,627
12	1200 CAFETERIA	-81,567	234,098
14	1400 NURSING ADMINISTRATION		149,570
17	1700 MEDICAL RECORDS & LIBRARY	-9,379	288,324
18	1800 SOCIAL SERVICE		109,378
20	2000 NONPHYSICIAN ANESTHETISTS	-583,722	63,605
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS		1,460,718
26	2600 INTENSIVE CARE UNIT		242,115
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		802,824
40	4000 ANESTHESIOLOGY		
41	4100 RADIOLOGY-DIAGNOSTIC	62,149	1,352,827
44	4400 LABORATORY	-6,250	1,231,185
49	4900 RESPIRATORY THERAPY	-99,973	429,534
50	5000 PHYSICAL THERAPY		516,084
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	-5,741	1,566,954
55.30	5530 IMPL. DEV. CHARGED TO PATIENT		116,309
56	5600 DRUGS CHARGED TO PATIENTS	-1,564	1,655,284
59	3480 ONCOLOGY	-130,400	193,560
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC		26,183
61	6100 EMERGENCY	-1,189,653	1,312,216
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950 OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310 RURAL HEALTH CLINIC		175,538
	OTHER REIMBURS COST CNTRS		
65	6500 AMBULANCE SERVICES		540,174
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
95	SUBTOTALS	-2,430,739	21,696,582
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800 PHYSICIANS' PRIVATE OFFICES		2,925,015
101	TOTAL	-2,430,739	24,621,597

COST CENTERS USED IN COST REPORT

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
20	NONPHYSICIAN ANESTHETISTS	2000	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
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	
59	ONCOLOGY	3480	ONCOLOGY
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141327	FROM 1/ 1/2010	5/16/2011
	TO 12/31/2010	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE	
	(1)	COST CENTER	LINE NO	
	1	2	3	4
1 RENT	A	NEW CAP REL COSTS-MVBLE EQUIP	4	321,155
2				
3				
4				
5				
6				
7				
8				
9				
10 CAFETERIA	B	CAFETERIA	12	181,680
11 IV SOLUTIONS	C	DRUGS CHARGED TO PATIENTS	56	5,792
12 MATERIAL MANAGEMENT	D	ADMINISTRATIVE & GENERAL	6	53,775
13 INTEREST	E	NEW CAP REL COSTS-MVBLE EQUIP	4	327,200
14 OXYGEN	F	MEDICAL SUPPLIES CHARGED TO PATIENTS	55	9,329
15				
16				
17 MED SUPPLIES	G	MEDICAL SUPPLIES CHARGED TO PATIENTS	55	134,978
18		IMPL. DEV. CHARGED TO PATIENT	55.30	116,309
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30 UTILITIES	H	OPERATION OF PLANT	8	30,666
36 TOTAL RECLASSIFICATIONS				181,680
				1,133,189

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141327	FROM 1/ 1/2010	5/16/2011
	TO 12/31/2010	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE		SALARY	OTHER	A-7 REF
			LINE NO	7			
	1	6			8	9	10
1 RENT	A	ADMINISTRATIVE & GENERAL	6			3,328	10
2		DIETARY	11			1,090	
3		MEDICAL RECORDS & LIBRARY	17			5,068	
4		OPERATING ROOM	37			31,708	
5		RADIOLOGY-DIAGNOSTIC	41			141,910	
6		LABORATORY	44			25,690	
7		RESPIRATORY THERAPY	49			7,560	
8		AMBULANCE SERVICES	65			12,000	
9		PHYSICIANS' PRIVATE OFFICES	98			92,801	
10 CAFETERIA	B	DIETARY	11		181,680	133,985	
11 IV SOLUTIONS	C	MEDICAL SUPPLIES CHARGED TO PATIENTS	55			5,792	
12 MATERIAL MANAGEMENT	D	MEDICAL SUPPLIES CHARGED TO PATIENTS	55			53,775	
13 INTEREST	E	INTEREST EXPENSE	88			327,200	11
14 OXYGEN	F						
15		RESPIRATORY THERAPY	49			8,493	
16		AMBULANCE SERVICES	65			836	
17 MED SUPPLIES	G	NONPHYSICIAN ANESTHETISTS	20			2,268	
18		ADULTS & PEDIATRICS	25			51,497	
19		INTENSIVE CARE UNIT	26			2,658	
20		OPERATING ROOM	37			47,468	
21		RADIOLOGY-DIAGNOSTIC	41			9,359	
22		LABORATORY	44			39,909	
23		RESPIRATORY THERAPY	49			2,091	
24		PHYSICAL THERAPY	50			1,168	
25		DRUGS CHARGED TO PATIENTS	56			10,101	
26		ONCOLOGY	59			30,121	
27		EMERGENCY	61			46,525	
28		RURAL HEALTH CLINIC	63.50			1,819	
29		AMBULANCE SERVICES	65			6,303	
30 UTILITIES	H	PHYSICIANS' PRIVATE OFFICES	98			30,666	
36 TOTAL RECLASSIFICATIONS					181,680	1,133,189	

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141327	FROM 1/ 1/2010	5/16/2011
	TO 12/31/2010	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: A  
EXPLANATION : RENT

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	321,155
2.00			0
3.00			0
5.00			0
6.00			0
7.00			0
8.00			0
9.00			0
10.00			0
TOTAL RECLASSIFICATIONS FOR CODE A			321,155

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	3,328	
DIETARY	11	1,090	
MEDICAL RECORDS & LIBRARY	17	5,068	
OPERATING ROOM	37	31,708	
RADIOLOGY-DIAGNOSTIC	41	141,910	
LABORATORY	44	25,690	
RESPIRATORY THERAPY	49	7,560	
AMBULANCE SERVICES	65	12,000	
PHYSICIANS' PRIVATE OFFICES	98	92,801	
		321,155	

RECLASS CODE: B  
EXPLANATION : CAFETERIA

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	315,665
TOTAL RECLASSIFICATIONS FOR CODE B			315,665

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
DIETARY	11	315,665	
		315,665	

RECLASS CODE: C  
EXPLANATION : IV SOLUTIONS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	56	5,792
TOTAL RECLASSIFICATIONS FOR CODE C			5,792

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
MEDICAL SUPPLIES CHARGED TO PA	55	5,792	
		5,792	

RECLASS CODE: D  
EXPLANATION : MATERIAL MANAGEMENT

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	53,775
TOTAL RECLASSIFICATIONS FOR CODE D			53,775

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
MEDICAL SUPPLIES CHARGED TO PA	55	53,775	
		53,775	

RECLASS CODE: E  
EXPLANATION : INTEREST

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	327,200
TOTAL RECLASSIFICATIONS FOR CODE E			327,200

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
INTEREST EXPENSE	88	327,200	
		327,200	

RECLASS CODE: F  
EXPLANATION : OXYGEN

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	9,329
3.00			0
4.00			0
TOTAL RECLASSIFICATIONS FOR CODE F			9,329

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
		0	
RESPIRATORY THERAPY	49	8,493	
AMBULANCE SERVICES	65	836	
		9,329	

RECLASS CODE: G  
EXPLANATION : MED SUPPLIES

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	134,978
2.00	IMPL. DEV. CHARGED TO PATIENT	55.30	116,309
3.00			0
4.00			0
5.00			0
6.00			0
7.00			0
8.00			0
9.00			0
10.00			0
11.00			0

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
NONPHYSICIAN ANESTHETISTS	20	2,268	
ADULTS & PEDIATRICS	25	51,497	
INTENSIVE CARE UNIT	26	2,658	
OPERATING ROOM	37	47,468	
RADIOLOGY-DIAGNOSTIC	41	9,359	
LABORATORY	44	39,909	
RESPIRATORY THERAPY	49	2,091	
PHYSICAL THERAPY	50	1,168	
DRUGS CHARGED TO PATIENTS	56	10,101	
ONCOLOGY	59	30,121	
EMERGENCY	61	46,525	

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141327	FROM 1/ 1/2010	5/16/2011
	TO 12/31/2010	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: G  
EXPLANATION : MED SUPPLIES

----- INCREASE -----				----- DECREASE -----		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
12.00			0	RURAL HEALTH CLINIC	63.50	1,819
13.00			0	AMBULANCE SERVICES	65	6,303
TOTAL RECLASSIFICATIONS FOR CODE G			251,287	251,287		

RECLASS CODE: H  
EXPLANATION : UTILITIES

----- INCREASE -----				----- DECREASE -----		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OPERATION OF PLANT	8	30,666	PHYSICIANS' PRIVATE OFFICES	98	30,666
TOTAL RECLASSIFICATIONS FOR CODE H			30,666	30,666		

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
			DONATION 3					
1 LAND	416,867						416,867	
2 LAND IMPROVEMENTS	543,851	44,694			44,694		588,545	
3 BUILDINGS & FIXTURE	13,167,869	1,760,311			1,760,311		14,928,180	
4 BUILDING IMPROVEMEN								
5 FIXED EQUIPMENT	3,014,543						3,014,543	
6 MOVABLE EQUIPMENT	7,734,912	687,416			687,416		8,422,328	
7 SUBTOTAL	24,878,042	2,492,421			2,492,421		27,370,463	
8 RECONCILING ITEMS								
9 TOTAL	24,878,042	2,492,421			2,492,421		27,370,463	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION	GROSS ASSETS	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL
		CAPITLIZED 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	18,948,135		18,948,135	.692284				
4 NEW CAP REL COSTS-MV	8,422,328		8,422,328	.307716				
5 TOTAL	27,370,463		27,370,463	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	423,781						423,781
4 NEW CAP REL COSTS-MV	514,649	321,155	327,200				1,163,004
5 TOTAL	938,430	321,155	327,200				1,586,785

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	423,781						423,781
4 NEW CAP REL COSTS-MV	602,385						602,385
5 TOTAL	1,026,166						1,026,166

\* 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 14-1327  
I

I PERIOD:  
I FROM 1/ 1/2010 I PREPARED 5/16/2011  
I TO 12/31/2010 I WORKSHEET A-8

DESCRIPTION (1)	(2)		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			WKST. A-7 REF. 5
	BASIS/CODE 1	AMOUNT 2	COST CENTER 3	LINE NO 4		
1 INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1		
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2		
3 INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3		
4 INVESTMENT INCOME-NEW MOVABLE EQUIP	B	-87,736	NEW CAP REL COSTS-MVBLE E	4	9	
5 INVESTMENT INCOME-OTHER						
6 TRADE, QUANTITY AND TIME DISCOUNTS	B	-14,200	ADMINISTRATIVE & GENERAL	6		
7 REFUNDS AND REBATES OF EXPENSES						
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS						
9 TELEPHONE SERVICES						
10 TELEVISION AND RADIO SERVICE						
11 PARKING LOT						
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-1,431,130				
13 SALE OF SCRAP, WASTE, ETC.						
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1	67,003				
15 LAUNDRY AND LINEN SERVICE						
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-81,567	CAFETERIA	12		
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS						
18 SALE OF MED AND SURG SUPPLIES	B	-5,741	MEDICAL SUPPLIES CHARGED	55		
19 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-1,564	DRUGS CHARGED TO PATIENTS	56		
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-9,379	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			NONPHYSICIAN ANESTHETISTS	20		
34 PHYSICIANS' ASSISTANT						
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51		
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52		
37 DIETARY	B	-5,927	DIETARY	11		
38						
39 MISCELLANEOUS	B	-45,049	ADMINISTRATIVE & GENERAL	6		
40 PHYSICIAN RECRUITMENT	A	-109,197	ADMINISTRATIVE & GENERAL	6		
41 PUBLIC RELATIONS	A	-210,265	ADMINISTRATIVE & GENERAL	6		
42						
43 CRNA	A	-583,722	NONPHYSICIAN ANESTHETISTS	20		
44 EMPLOYEE DISCOUNT	A	87,735	EMPLOYEE BENEFITS	5		
45						
46 OTHER ADJUSTMENTS (SPECIFY)						
47 OTHER ADJUSTMENTS (SPECIFY)						
48 OTHER ADJUSTMENTS (SPECIFY)						
49 OTHER ADJUSTMENTS (SPECIFY)						
50 TOTAL (SUM OF LINES 1 THRU 49)		-2,430,739				

(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	41	RADIOLOGY-DIAGNOSTIC	208,913	141,910	67,003	
2						
3						
4						
5		TOTALS	208,913	141,910	67,003	

\* 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	A	DSS MRI		100.00	0.00
2				0.00	0.00
3				0.00	0.00
4				0.00	0.00
5				0.00	0.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I  
I 14-1327 I  
I

I PERIOD: I PREPARED 5/16/2011  
I FROM 1/ 1/2010 I WORKSHEET A-8-2  
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	41 RADIOLOGY	4,854	4,854					
2	44 LAB	6,250	6,250					
3	49 RT	99,973	99,973					
4	59 ONCOLOGY	130,400	130,400					
5	61 ER	1,672,775	1,189,653	483,122				
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	1,914,252	1,431,130	483,122				



COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
 I 14-1327 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	3	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	3	SQUARE	FEET	ENTERED
10	HOUSEKEEPING	9	POUNDS		ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	11	FTE'S		ENTERED
14	NURSING ADMINISTRATION	13	NURSE FTE'S		ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME	SPENT	ENTERED
18	SOCIAL SERVICE	17	DAYS		ENTERED
20	NONPHYSICIAN ANESTHETISTS	18	ASSIGNED	TIME	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
 I 14-1327 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 &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
	0	3	4	5	5a.00	6	8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	423,781	423,781					
005 NEW CAP REL COSTS-MVBLE E	1,163,004		1,163,004				
005 EMPLOYEE BENEFITS	3,746,339	1,128		3,097	3,750,564		
006 ADMINISTRATIVE & GENERAL	2,665,359	34,080		93,528	297,166	3,090,133	
008 OPERATION OF PLANT	794,667	20,218		55,485	48,837	131,922	1,051,129
010 HOUSEKEEPING	280,325	5,062		13,893	80,587	379,867	54,517
011 DIETARY	156,627	32,160		88,259	32,779	309,825	44,465
012 CAFETERIA	234,098				63,230	297,328	42,672
014 NURSING ADMINISTRATION	149,570	2,429		6,667	48,973	207,639	29,800
017 MEDICAL RECORDS & LIBRARY	288,324	9,137		25,076	92,591	415,128	59,578
018 SOCIAL SERVICE	109,378	3,017		8,280	35,286	155,961	22,383
020 NONPHYSICIAN ANESTHETISTS	63,605				203,152	266,757	38,284
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	1,460,718	79,109		217,099	404,103	2,161,029	310,144
026 INTENSIVE CARE UNIT	242,115	19,826		54,409	82,431	398,781	57,232
026 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	802,824	54,682		150,066	198,364	1,205,936	173,072
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	1,352,827	38,304		105,120	200,561	1,696,812	243,521
044 LABORATORY	1,231,185	7,899		21,678	232,892	1,493,654	214,365
049 RESPIRATORY THERAPY	429,534	8,698		23,871	131,179	593,282	85,146
050 PHYSICAL THERAPY	516,084	16,550		45,420	168,375	746,429	107,125
055 MEDICAL SUPPLIES CHARGED	1,566,954	10,391		28,516	34,034	1,639,895	235,353
055 30 IMPL. DEV. CHARGED TO PAT	116,309					116,309	16,692
056 DRUGS CHARGED TO PATIENTS	1,655,284	3,965		10,882	106,980	1,777,111	255,046
059 ONCOLOGY	193,560	10,462		28,710	62,800	295,532	42,414
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC	26,183				8,602	34,785	4,992
061 EMERGENCY	1,312,216	25,727		70,603	271,880	1,680,426	241,170
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	175,538	7,844		21,527	59,606	264,515	37,962
065 OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES	540,174	27,960		76,732	154,823	799,689	114,769
065 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	21,696,582	418,648	1,148,918	3,019,231	20,946,030	2,562,624	1,036,482
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP		2,006		5,505		7,511	1,078
098 PHYSICIANS' PRIVATE OFFIC	2,925,015	3,127		8,581	731,333	3,668,056	526,431
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	24,621,597	423,781	1,163,004	3,750,564	24,621,597	3,090,133	1,051,129

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
 I 14-1327 I FROM 1/ 1/2010 I WORKSHEET B  
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN	MEDICAL RECOR	SOCIAL SERVIC	NONPHYSICIAN
	10	11	12	14	17	18	20
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL							
010 OPERATION OF PLANT							
011 HOUSEKEEPING	448,830						
012 DIETARY	8,640	454,702					
014 CAFETERIA			340,000				
017 NURSING ADMINISTRATION			3,507	247,878			
018 MEDICAL RECORDS & LIBRARY			20,908		521,688		
020 SOCIAL SERVICE			5,099			192,052	
025 NONPHYSICIAN ANESTHETISTS			6,637				311,678
026 INPAT ROUTINE SRVC CNTRS							
037 ADULTS & PEDIATRICS	210,995	440,174	64,234	114,313	453,921	185,916	
040 INTENSIVE CARE UNIT		14,528	10,386	18,484	30,414	6,136	
041 ANCILLARY SRVC COST CNTRS							
044 OPERATING ROOM	70,574		25,710	45,754			
049 ANESTHESIOLOGY							311,678
050 RADIOLOGY-DIAGNOSTIC	38,191		27,436				
055 LABORATORY	2,565		32,346				
059 RESPIRATORY THERAPY	5,034		19,262				
060 PHYSICAL THERAPY	28,244		19,073				
061 MEDICAL SUPPLIES CHARGED			2,833				
062 30 IMPL. DEV. CHARGED TO PAT			12,086				
063 DRUGS CHARGED TO PATIENTS			10,144				
065 ONCOLOGY	1,743						
066 OUTPAT SERVICE COST CNTRS							
067 CLINIC			2,023				
068 EMERGENCY	81,561		38,956	69,327	37,353		
069 OBSERVATION BEDS (NON-DIS							
070 OTHER OUTPATIENT SERVICE							
071 50 RURAL HEALTH CLINIC			5,611				
072 OTHER REIMBURS COST CNTRS							
075 AMBULANCE SERVICES	1,283		33,749				
076 SPEC PURPOSE COST CENTERS							
085 SUBTOTALS	448,830	454,702	340,000	247,878	521,688	192,052	311,678
096 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP							
101 PHYSICIANS' PRIVATE OFFIC							
102 CROSS FOOT ADJUSTMENT							
103 NEGATIVE COST CENTER							
TOTAL	448,830	454,702	340,000	247,878	521,688	192,052	311,678

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
 I 14-1327 I FROM 1/ 1/2010 I WORKSHEET B  
 I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	25	26	27
003 GENERAL SERVICE COST CNTR			
004 NEW CAP REL COSTS-BLDG &			
005 NEW CAP REL COSTS-MVBLE E			
006 EMPLOYEE BENEFITS			
008 ADMINISTRATIVE & GENERAL			
010 OPERATION OF PLANT			
011 HOUSEKEEPING			
012 DIETARY			
014 CAFETERIA			
017 NURSING ADMINISTRATION			
018 MEDICAL RECORDS & LIBRARY			
020 SOCIAL SERVICE			
025 NONPHYSICIAN ANESTHETISTS			
026 INPAT ROUTINE SRVC CNTRS	4,166,467		4,166,467
ADULTS & PEDIATRICS	592,536		592,536
037 INTENSIVE CARE UNIT			
040 ANCILLARY SRVC COST CNTRS	1,677,085		1,677,085
041 OPERATING ROOM	311,678		311,678
044 ANESTHESIOLOGY	2,115,263		2,115,263
049 RADIOLOGY-DIAGNOSTIC	1,765,470		1,765,470
050 LABORATORY	727,545		727,545
055 RESPIRATORY THERAPY	948,099		948,099
055 30 PHYSICAL THERAPY	1,907,732		1,907,732
056 MEDICAL SUPPLIES CHARGED	133,001		133,001
059 IMPL. DEV. CHARGED TO PAT	2,055,558		2,055,558
ONCOLOGY	379,686		379,686
060 OUTPAT SERVICE COST CNTRS			
061 CLINIC	41,800		41,800
062 EMERGENCY	2,222,206		2,222,206
063 OBSERVATION BEDS (NON-DIS			
063 50 OTHER OUTPATIENT SERVICE			
RURAL HEALTH CLINIC	330,472		330,472
065 OTHER REIMBURS COST CNTRS			
AMBULANCE SERVICES	1,029,276		1,029,276
095 SPEC PURPOSE COST CENTERS			
SUBTOTALS	20,403,874		20,403,874
096 NONREIMBURS COST CENTERS			
098 GIFT, FLOWER, COFFEE SHOP	14,314		14,314
101 PHYSICIANS' PRIVATE OFFIC	4,203,409		4,203,409
102 CROSS FOOT ADJUSTMENT			
103 NEGATIVE COST CENTER			
TOTAL	24,621,597		24,621,597

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
 I 14-1327 I FROM 1/ 1/2010 I WORKSHEET B  
 I I TO 12/31/2010 I PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
	0	3	4	4a	5	6	8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS		1,128	3,097	4,225	4,225		
006 ADMINISTRATIVE & GENERAL		34,080	93,528	127,608	335	127,943	
008 OPERATION OF PLANT		20,218	55,485	75,703	55	5,462	81,220
010 HOUSEKEEPING		5,062	13,893	18,955	91	2,257	1,116
011 DIETARY		32,160	88,259	120,419	37	1,841	7,091
012 CAFETERIA					71	1,767	
014 NURSING ADMINISTRATION		2,429	6,667	9,096	55	1,234	536
017 MEDICAL RECORDS & LIBRARY		9,137	25,076	34,213	104	2,467	2,015
018 SOCIAL SERVICE		3,017	8,280	11,297	40	927	665
020 NONPHYSICIAN ANESTHETISTS					229	1,585	
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS		79,109	217,099	296,208	455	12,841	17,443
026 INTENSIVE CARE UNIT		19,826	54,409	74,235	93	2,370	4,371
037 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM		54,682	150,066	204,748	223	7,166	12,057
041 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC		38,304	105,120	143,424	226	10,082	8,446
044 LABORATORY		7,899	21,678	29,577	262	8,875	1,742
049 RESPIRATORY THERAPY		8,698	23,871	32,569	148	3,525	1,918
050 PHYSICAL THERAPY		16,550	45,420	61,970	190	4,435	3,649
055 MEDICAL SUPPLIES CHARGED		10,391	28,516	38,907	38	9,744	2,291
055 30 IMPL. DEV. CHARGED TO PAT						691	
056 DRUGS CHARGED TO PATIENTS		3,965	10,882	14,847	120	10,560	874
059 ONCOLOGY		10,462	28,710	39,172	71	1,756	2,307
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC					10	207	
061 EMERGENCY		25,727	70,603	96,330	306	9,985	5,673
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC		7,844	21,527	29,371	67	1,572	1,730
063 OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES		27,960	76,732	104,692	174	4,752	6,165
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS		418,648	1,148,918	1,567,566	3,400	106,101	80,089
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP		2,006	5,505	7,511		45	442
098 PHYSICIANS' PRIVATE OFFIC		3,127	8,581	11,708	825	21,797	689
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		423,781	1,163,004	1,586,785	4,225	127,943	81,220

ALLOCATION OF NEW CAPITAL RELATED COSTS

PROVIDER NO: 14-1327  
 PERIOD: FROM 1/1/2010 TO 12/31/2010  
 PREPARED 5/16/2011  
 WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS
	10	11	12	14	17	18	20
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL							
010 OPERATION OF PLANT							
011 HOUSEKEEPING	22,419						
012 DIETARY	432	129,820					
014 CAFETERIA			1,838				
017 NURSING ADMINISTRATION			19	10,940			
018 MEDICAL RECORDS & LIBRARY			113		38,912		
020 SOCIAL SERVICE			28			12,957	
025 NONPHYSICIAN ANESTHETISTS			36				1,850
026 INPAT ROUTINE SRVC CNTRS							
ADULTS & PEDIATRICS	10,539	125,672	348	5,045	33,857	12,543	
026 INTENSIVE CARE UNIT		4,148	56	816	2,269	414	
037 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM	3,525		139	2,019			
041 ANESTHESIOLOGY							
044 RADIOLOGY-DIAGNOSTIC	1,908		148				
049 LABORATORY	128		175				
050 RESPIRATORY THERAPY	251		104				
055 PHYSICAL THERAPY	1,411		103				
055 MEDICAL SUPPLIES CHARGED			15				
055 30 IMPL. DEV. CHARGED TO PAT							
056 DRUGS CHARGED TO PATIENTS			65				
059 ONCOLOGY	87		55				
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC			11				
062 EMERGENCY	4,074		211	3,060	2,786		
063 OBSERVATION BEDS (NON-DIS							
063 50 OTHER OUTPATIENT SERVICE							
063 RURAL HEALTH CLINIC			30				
065 OTHER REIMBURS COST CNTRS							
AMBULANCE SERVICES	64		182				
095 SPEC PURPOSE COST CENTERS							
SUBTOTALS	22,419	129,820	1,838	10,940	38,912	12,957	
096 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP							
101 PHYSICIANS' PRIVATE OFFIC							1,850
102 CROSS FOOT ADJUSTMENTS							
103 NEGATIVE COST CENTER							
TOTAL	22,419	129,820	1,838	10,940	38,912	12,957	1,850

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
 I 14-1327 I FROM 1/ 1/2010 I WORKSHEET B  
 I I TO 12/31/2010 I PART III

COST CENTER DESCRIPTION	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	25	26	27
003 GENERAL SERVICE COST CNTR			
004 NEW CAP REL COSTS-BLDG &			
005 NEW CAP REL COSTS-MVBLE E			
006 EMPLOYEE BENEFITS			
008 ADMINISTRATIVE & GENERAL			
010 OPERATION OF PLANT			
011 HOUSEKEEPING			
012 DIETARY			
014 CAFETERIA			
017 NURSING ADMINISTRATION			
018 MEDICAL RECORDS & LIBRARY			
020 SOCIAL SERVICE			
025 NONPHYSICIAN ANESTHETISTS			
026 INPAT ROUTINE SRVC CNTRS			
ADULTS & PEDIATRICS	514,951		514,951
INTENSIVE CARE UNIT	88,772		88,772
ANCILLARY SRVC COST CNTRS			
037 OPERATING ROOM	229,877		229,877
040 ANESTHESIOLOGY			
041 RADIOLOGY-DIAGNOSTIC	164,234		164,234
044 LABORATORY	40,759		40,759
049 RESPIRATORY THERAPY	38,515		38,515
050 PHYSICAL THERAPY	71,758		71,758
055 MEDICAL SUPPLIES CHARGED	50,995		50,995
055 30 IMPL. DEV. CHARGED TO PAT	691		691
056 DRUGS CHARGED TO PATIENTS	26,466		26,466
059 ONCOLOGY	43,448		43,448
OUTPAT SERVICE COST CNTRS			
060 CLINIC	228		228
061 EMERGENCY	122,425		122,425
062 OBSERVATION BEDS (NON-DIS			
063 OTHER OUTPATIENT SERVICE			
063 50 RURAL HEALTH CLINIC	32,770		32,770
OTHER REIMBURS COST CNTRS			
065 AMBULANCE SERVICES	116,029		116,029
SPEC PURPOSE COST CENTERS			
095 SUBTOTALS	1,541,918		1,541,918
NONREIMBURS COST CENTERS			
096 GIFT, FLOWER, COFFEE SHOP	7,998		7,998
098 PHYSICIANS' PRIVATE OFFIC	35,019		35,019
101 CROSS FOOT ADJUSTMENTS	1,850		1,850
102 NEGATIVE COST CENTER			
103 TOTAL	1,586,785		1,586,785

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
 I 14-1327 I FROM 1/ 1/2010 I WORKSHEET B-1  
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	RECONCILIATION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT
	OSTS-BLDG & (SQUARE FEET)	OSTS-MVBLE E (SQUARE FEET)	FITS ( GROSS SALARIES )		E & GENERAL ( ACCUM. COST )	PLANT ( SQUARE FEET )
	3	4	5	6a.00	6	8
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	54,079					
005 NEW CAP REL COSTS-MVB		54,079				
006 EMPLOYEE BENEFITS	144	144	10,776,586			
008 ADMINISTRATIVE & GENE	4,349	4,349	853,853	-3,090,133	21,531,464	
010 OPERATION OF PLANT	2,580	2,580	140,324		919,207	47,006
011 HOUSEKEEPING	646	646	231,553		379,867	646
012 DIETARY	4,104	4,104	94,184		309,825	4,104
014 CAFETERIA			181,680		297,328	
017 NURSING ADMINISTRATIO	310	310	140,716		207,639	310
018 MEDICAL RECORDS & LIB	1,166	1,166	266,045		415,128	1,166
020 SOCIAL SERVICE	385	385	101,389		155,961	385
025 NONPHYSICIAN ANESTHET			583,722		266,757	
026 INPAT ROUTINE SRVC CN						
037 ADULTS & PEDIATRICS	10,095	10,095	1,161,119		2,161,029	10,095
040 INTENSIVE CARE UNIT	2,530	2,530	236,852		398,781	2,530
041 ANCILLARY SRVC COST C						
044 OPERATING ROOM	6,978	6,978	569,965		1,205,936	6,978
049 ANESTHESIOLOGY						
050 RADIOLOGY-DIAGNOSTIC	4,888	4,888	576,276		1,696,812	4,888
055 LABORATORY	1,008	1,008	669,175		1,493,654	1,008
056 RESPIRATORY THERAPY	1,110	1,110	376,921		593,282	1,110
059 PHYSICAL THERAPY	2,112	2,112	483,796		746,429	2,112
060 MEDICAL SUPPLIES CHAR	1,326	1,326	97,791		1,639,895	1,326
061 30 IMPL. DEV. CHARGED TO					116,309	
062 DRUGS CHARGED TO PATI	506	506	307,387		1,777,111	506
063 ONCOLOGY	1,335	1,335	180,445		295,532	1,335
066 OUTPAT SERVICE COST C						
067 CLINIC			24,716		34,785	
068 EMERGENCY	3,283	3,283	781,200		1,680,426	3,283
069 OBSERVATION BEDS (NON						
070 OTHER OUTPATIENT SERV						
071 50 RURAL HEALTH CLINIC	1,001	1,001	171,268		264,515	1,001
072 OTHER REIMBURS COST C						
073 AMBULANCE SERVICES	3,568	3,568	444,857		799,689	3,568
074 SPEC PURPOSE COST CEN						
075 SUBTOTALS	53,424	53,424	8,675,234	-3,090,133	17,855,897	46,351
076 NONREIMBURS COST CENT						
077 GIFT, FLOWER, COFFEE	256	256			7,511	256
078 PHYSICIANS' PRIVATE O	399	399	2,101,352		3,668,056	399
079 CROSS FOOT ADJUSTMENT						
080 NEGATIVE COST CENTER						
081 COST TO BE ALLOCATED	423,781	1,163,004	3,750,564		3,090,133	1,051,129
082 (WRKSHT B, PART I)						
083 UNIT COST MULTIPLIER	7.836332		.348029		.143517	22.361592
084 (WRKSHT B, PT I)		21.505649				
085 COST TO BE ALLOCATED						
086 (WRKSHT B, PART II)						
087 UNIT COST MULTIPLIER			4,225		127,943	81,220
088 (WRKSHT B, PT II)						
089 COST TO BE ALLOCATED						
090 (WRKSHT B, PART III)						
091 UNIT COST MULTIPLIER			.000392		.005942	1.727865
092 (WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
 I 14-1327 I FROM 1/ 1/2010 I WORKSHEET B-1  
 I I TO 12/31/2010 I

	COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN	MEDICAL RECOR	SOCIAL SERVIC	NONPHYSICIAN
		(POUNDS)	(MEALS SERVED)	S(FTE'S)	(NURSE FTE'S)	(TIME SPENT)	(DAYS)	(ASSIGNED TIME)
		10	11	12	14	17	18	20
003	GENERAL SERVICE COST							
004	NEW CAP REL COSTS-BLD							
005	NEW CAP REL COSTS-MVB							
006	EMPLOYEE BENEFITS							
008	ADMINISTRATIVE & GENE							
010	OPERATION OF PLANT							
011	HOUSEKEEPING	18,545						
012	DIETARY	357	9,108					
014	CAFETERIA			12,603				
017	NURSING ADMINISTRATIO			130	5,163			
018	MEDICAL RECORDS & LIB			775		10,000		
020	SOCIAL SERVICE			189			3,036	
025	NONPHYSICIAN ANESTHET			246				100
026	INPAT ROUTINE SRVC CN							
026	ADULTS & PEDIATRICS	8,718	8,817	2,381	2,381	8,701	2,939	
037	INTENSIVE CARE UNIT		291	385	385	583	97	
040	ANCILLARY SRVC COST C							
041	OPERATING ROOM	2,916		953	953			100
044	ANESTHESIOLOGY							
049	RADIOLOGY-DIAGNOSTIC	1,578		1,017				
050	LABORATORY	106		1,199				
055	RESPIRATORY THERAPY	208		714				
056	PHYSICAL THERAPY	1,167		707				
059	MEDICAL SUPPLIES CHAR			105				
060	30 IMPL. DEV. CHARGED TO							
061	DRUGS CHARGED TO PATI			448				
062	ONCOLOGY	72		376				
063	OUTPAT SERVICE COST C							
063	CLINIC			75				
065	EMERGENCY	3,370		1,444	1,444	716		
095	OBSERVATION BEDS (NON							
095	OTHER OUTPATIENT SERV							
095	50 RURAL HEALTH CLINIC			208				
095	OTHER REIMBURS COST C							
095	AMBULANCE SERVICES	53		1,251				
095	SPEC PURPOSE COST CEN							
095	SUBTOTALS	18,545	9,108	12,603	5,163	10,000	3,036	100
096	NONREIMBURS COST CENT							
101	GIFT, FLOWER, COFFEE							
102	PHYSICIANS' PRIVATE O							
103	CROSS FOOT ADJUSTMENT							
103	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED	448,830	454,702	340,000	247,878	521,688	192,052	311,678
104	(WRKSHT B, PART I)							
104	UNIT COST MULTIPLIER		49.923364		48.010459		63.258235	3,116.780000
104	(WRKSHT B, PT I)	24.202211		26.977704		52.168800		
105	COST TO BE ALLOCATED							
106	(WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER							
106	(WRKSHT B, PT II)							
107	COST TO BE ALLOCATED	22,419	129,820	1,838	10,940	38,912	12,957	1,850
107	(WRKSHT B, PART III)							
108	UNIT COST MULTIPLIER		14.253404		2.118923		4.267787	
108	(WRKSHT B, PT III)	1.208897		.145838		3.891200		18.500000

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
 I 14-1327 I FROM 1/ 1/2010 I WORKSHEET C  
 I I TO 12/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS					
	ADULTS & PEDIATRICS	4,166,467		4,166,467		
26	INTENSIVE CARE UNIT	592,536		592,536		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,677,085		1,677,085		
40	ANESTHESIOLOGY	311,678		311,678		
41	RADIOLOGY-DIAGNOSTIC	2,115,263		2,115,263		
44	LABORATORY	1,765,470		1,765,470		
49	RESPIRATORY THERAPY	727,545		727,545		
50	PHYSICAL THERAPY	948,099		948,099		
55	MEDICAL SUPPLIES CHARGED	1,907,732		1,907,732		
55 30	IMPL. DEV. CHARGED TO PAT	133,001		133,001		
56	DRUGS CHARGED TO PATIENTS	2,055,558		2,055,558		
59	ONCOLOGY	379,686		379,686		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	41,800		41,800		
61	EMERGENCY	2,222,206		2,222,206		
62	OBSERVATION BEDS (NON-DIS	801,671		801,671		
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	330,472		330,472		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	1,029,276		1,029,276		
101	SUBTOTAL	21,205,545		21,205,545		
102	LESS OBSERVATION BEDS	801,671		801,671		
103	TOTAL	20,403,874		20,403,874		

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
 I 14-1327 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
25	INPAT ROUTINE SRVC CNTRS						
	ADULTS & PEDIATRICS	2,991,129		2,991,129			
26	INTENSIVE CARE UNIT	113,050		113,050			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	2,185,190	4,585,195	6,770,385	.247709	.247709	
40	ANESTHESIOLOGY	482,833	625,992	1,108,825	.281089	.281089	
41	RADIOLOGY-DIAGNOSTIC	708,775	10,018,273	10,727,048	.197190	.197190	
44	LABORATORY	929,211	8,055,629	8,984,840	.196494	.196494	
49	RESPIRATORY THERAPY	410,539	1,165,894	1,576,433	.461513	.461513	
50	PHYSICAL THERAPY	282,113	1,161,351	1,443,464	.656822	.656822	
55	MEDICAL SUPPLIES CHARGED	1,044,122	944,476	1,988,598	.959335	.959335	
55	30 IMPL. DEV. CHARGED TO PAT	1,520,870	192,686	1,713,556	.077617	.077617	
56	DRUGS CHARGED TO PATIENTS	1,651,761	3,139,612	4,791,373	.429012	.429012	
59	ONCOLOGY		657,562	657,562	.577415	.577415	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		77,991	77,991	.535959	.535959	
61	EMERGENCY	70,449	3,250,914	3,321,363	.669064	.669064	
62	OBSERVATION BEDS (NON-DIS	9,237	503,989	513,226	1.562023	1.562023	
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC		384,464	384,464	.859566	.859566	
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		1,241,978	1,241,978	.828739	.828739	
101	SUBTOTAL	12,399,279	36,006,006	48,405,285			
102	LESS OBSERVATION BEDS						
103	TOTAL	12,399,279	36,006,006	48,405,285			

COMPUTATION OF RATIO OF COSTS TO CHARGES  
SPECIAL TITLE XIX WORKSHEET

PROVIDER NO:  
14-1327

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

PREPARED 5/16/2011  
WORKSHEET C  
PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	4,166,467		4,166,467		
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS	592,536		592,536		
37	OPERATING ROOM	1,677,085		1,677,085		
40	ANESTHESIOLOGY	311,678		311,678		
41	RADIOLOGY-DIAGNOSTIC	2,115,263		2,115,263		
44	LABORATORY	1,765,470		1,765,470		
49	RESPIRATORY THERAPY	727,545		727,545		
50	PHYSICAL THERAPY	948,099		948,099		
55	MEDICAL SUPPLIES CHARGED	1,907,732		1,907,732		
55	30 IMPL. DEV. CHARGED TO PAT	133,001		133,001		
56	DRUGS CHARGED TO PATIENTS	2,055,558		2,055,558		
59	ONCOLOGY	379,686		379,686		
60	OUTPAT SERVICE COST CNTRS CLINIC	41,800		41,800		
61	EMERGENCY	2,222,206		2,222,206		
62	OBSERVATION BEDS (NON-DIS	801,671		801,671		
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC	330,472		330,472		
65	OTHER REIMBURS COST CNTRS AMBULANCE SERVICES	1,029,276		1,029,276		
101	SUBTOTAL	21,205,545		21,205,545		
102	LESS OBSERVATION BEDS	801,671		801,671		
103	TOTAL	20,403,874		20,403,874		

COMPUTATION OF RATIO OF COSTS TO CHARGES  
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,991,129		2,991,129			
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS	113,050		113,050			
37	OPERATING ROOM	2,185,190	4,585,195	6,770,385	.247709	.247709	
40	ANESTHESIOLOGY	482,833	625,992	1,108,825	.281089	.281089	
41	RADIOLOGY-DIAGNOSTIC	708,775	10,018,273	10,727,048	.197190	.197190	
44	LABORATORY	929,211	8,055,629	8,984,840	.196494	.196494	
49	RESPIRATORY THERAPY	410,539	1,165,894	1,576,433	.461513	.461513	
50	PHYSICAL THERAPY	282,113	1,161,351	1,443,464	.656822	.656822	
55	MEDICAL SUPPLIES CHARGED	1,044,122	944,476	1,988,598	.959335	.959335	
55	30 IMPL. DEV. CHARGED TO PAT	1,520,870	192,686	1,713,556	.077617	.077617	
56	DRUGS CHARGED TO PATIENTS	1,651,761	3,139,612	4,791,373	.429012	.429012	
59	ONCOLOGY OUTPAT SERVICE COST CNTRS		657,562	657,562	.577415	.577415	
60	CLINIC		77,991	77,991	.535959	.535959	
61	EMERGENCY	70,449	3,250,914	3,321,363	.669064	.669064	
62	OBSERVATION BEDS (NON-DIS	9,237	503,989	513,226	1.562023	1.562023	
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS		384,464	384,464	.859566	.859566	
65	AMBULANCE SERVICES		1,241,978	1,241,978	.828739	.828739	
101	SUBTOTAL	12,399,279	36,006,006	48,405,285			
102	LESS OBSERVATION BEDS						
103	TOTAL	12,399,279	36,006,006	48,405,285			

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	1,677,085	229,877	1,447,208			1,677,085
40	ANESTHESIOLOGY	311,678		311,678			311,678
41	RADIOLOGY-DIAGNOSTIC	2,115,263	164,234	1,951,029			2,115,263
44	LABORATORY	1,765,470	40,759	1,724,711			1,765,470
49	RESPIRATORY THERAPY	727,545	38,515	689,030			727,545
50	PHYSICAL THERAPY	948,099	71,758	876,341			948,099
55	MEDICAL SUPPLIES CHARGED	1,907,732	50,995	1,856,737			1,907,732
55	30 IMPL. DEV. CHARGED TO PAT	133,001	691	132,310			133,001
56	DRUGS CHARGED TO PATIENTS	2,055,558	26,466	2,029,092			2,055,558
59	ONCOLOGY	379,686	43,448	336,238			379,686
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	41,800	228	41,572			41,800
61	EMERGENCY	2,222,206	122,425	2,099,781			2,222,206
62	OBSERVATION BEDS (NON-DIS	801,671		801,671			801,671
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC	330,472	32,770	297,702			330,472
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	1,029,276	116,029	913,247			1,029,276
101	SUBTOTAL	16,446,542	938,195	15,508,347			16,446,542
102	LESS OBSERVATION BEDS	801,671		801,671			801,671
103	TOTAL	15,644,871	938,195	14,706,676			15,644,871

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	6,770,385	.247709	.247709
40	ANESTHESIOLOGY	1,108,825	.281089	.281089
41	RADIOLOGY-DIAGNOSTIC	10,727,048	.197190	.197190
44	LABORATORY	8,984,840	.196494	.196494
49	RESPIRATORY THERAPY	1,576,433	.461513	.461513
50	PHYSICAL THERAPY	1,443,464	.656822	.656822
55	MEDICAL SUPPLIES CHARGED	1,988,598	.959335	.959335
55	30 IMPL. DEV. CHARGED TO PAT	1,713,556	.077617	.077617
56	DRUGS CHARGED TO PATIENTS	4,791,373	.429012	.429012
59	ONCOLOGY	657,562	.577415	.577415
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	77,991	.535959	.535959
61	EMERGENCY	3,321,363	.669064	.669064
62	OBSERVATION BEDS (NON-DIS	513,226	1.562023	1.562023
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC	384,464	.859566	.859566
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	1,241,978	.828739	.828739
101	SUBTOTAL	45,301,106		
102	LESS OBSERVATION BEDS	513,226		
103	TOTAL	44,787,880		

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	1,677,085	229,877	1,447,208			1,677,085
40	ANESTHESIOLOGY	311,678		311,678			311,678
41	RADIOLOGY-DIAGNOSTIC	2,115,263	164,234	1,951,029			2,115,263
44	LABORATORY	1,765,470	40,759	1,724,711			1,765,470
49	RESPIRATORY THERAPY	727,545	38,515	689,030			727,545
50	PHYSICAL THERAPY	948,099	71,758	876,341			948,099
55	MEDICAL SUPPLIES CHARGED	1,907,732	50,995	1,856,737			1,907,732
55	30 IMPL. DEV. CHARGED TO PAT	133,001	691	132,310			133,001
56	DRUGS CHARGED TO PATIENTS	2,055,558	26,466	2,029,092			2,055,558
59	ONCOLOGY	379,686	43,448	336,238			379,686
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	41,800	228	41,572			41,800
61	EMERGENCY	2,222,206	122,425	2,099,781			2,222,206
62	OBSERVATION BEDS (NON-DIS	801,671		801,671			801,671
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC	330,472	32,770	297,702			330,472
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	1,029,276	116,029	913,247			1,029,276
101	SUBTOTAL	16,446,542	938,195	15,508,347			16,446,542
102	LESS OBSERVATION BEDS	801,671		801,671			801,671
103	TOTAL	15,644,871	938,195	14,706,676			15,644,871

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	6,770,385	.247709	.247709
40	ANESTHESIOLOGY	1,108,825	.281089	.281089
41	RADIOLOGY-DIAGNOSTIC	10,727,048	.197190	.197190
44	LABORATORY	8,984,840	.196494	.196494
49	RESPIRATORY THERAPY	1,576,433	.461513	.461513
50	PHYSICAL THERAPY	1,443,464	.656822	.656822
55	MEDICAL SUPPLIES CHARGED	1,988,598	.959335	.959335
55	30 IMPL. DEV. CHARGED TO PAT	1,713,556	.077617	.077617
56	DRUGS CHARGED TO PATIENTS	4,791,373	.429012	.429012
59	ONCOLOGY	657,562	.577415	.577415
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	77,991	.535959	.535959
61	EMERGENCY	3,321,363	.669064	.669064
62	OBSERVATION BEDS (NON-DIS	513,226	1.562023	1.562023
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC	384,464	.859566	.859566
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	1,241,978	.828739	.828739
101	SUBTOTAL	45,301,106		
102	LESS OBSERVATION BEDS	513,226		
103	TOTAL	44,787,880		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
37	ANCILLARY SRVC COST CNTRS					
	OPERATING ROOM	1,043,584	3,295,036			
40	ANESTHESIOLOGY	69,492	586,937			
41	RADIOLOGY-DIAGNOSTIC	1,515,411	8,195,790			
44	LABORATORY	909,161	6,715,012			
49	RESPIRATORY THERAPY	480,989	1,748,373			
50	PHYSICAL THERAPY	581,460	1,013,692			
55	MEDICAL SUPPLIES CHARGED	2,137,821	3,468,197			
55	30 IMPL. DEV. CHARGED TO PAT					
56	DRUGS CHARGED TO PATIENTS	1,098,671	2,822,173			
59	ONCOLOGY					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	80,714	16,457			
61	EMERGENCY	1,604,086	2,149,287			
62	OBSERVATION BEDS (NON-DIS	801,632	586,625			
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC					
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	714,321	1,042,533			
101	TOTAL	11,037,342	31,640,112			

COMPUTATION OF OUTPATIENT COST PER VISIT -  
RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
I 14-1327 I FROM 1/ 1/2010 I WORKSHEET C  
I TO 12/31/2010 I PART V

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT- PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT- PATIENT COSTS 7
37	ANCILLARY SRVC COST CNTRS							
	OPERATING ROOM	1,043,584		1,043,584	3,295,036			
40	ANESTHESIOLOGY	69,492		69,492	586,937			
41	RADIOLOGY-DIAGNOSTIC	1,515,411	5,086	1,520,497	8,195,790			
44	LABORATORY	909,161	5,000	914,161	6,715,012			
49	RESPIRATORY THERAPY	480,989	58,854	539,843	1,748,373			
50	PHYSICAL THERAPY	581,460		581,460	1,013,692			
55	MEDICAL SUPPLIES CHARGED	2,137,821		2,137,821	3,468,197			
55	30 IMPL. DEV. CHARGED TO PAT							
56	DRUGS CHARGED TO PATIENTS	1,098,671		1,098,671	2,822,173			
59	ONCOLOGY							
	OUTPAT SERVICE COST CNTRS							
60	CLINIC	80,714		80,714	16,457			
61	EMERGENCY	1,604,086	753,538	2,357,624	2,149,287			
62	OBSERVATION BEDS (NON-DIS	801,632		801,632	586,625			
63	OTHER OUTPATIENT SERVICE							
63	50 RURAL HEALTH CLINIC							
	OTHER REIMBURS COST CNTRS							
65	AMBULANCE SERVICES	714,321		714,321	1,042,533			
101	TOTAL	11,037,342	822,478	11,859,820	31,640,112			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

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 Radialogy
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.247709		.247709		
40 ANESTHESIOLOGY	.281089		.281089		
41 RADIOLOGY-DIAGNOSTIC	.197190		.197190		
44 LABORATORY	.196494		.196494		
49 RESPIRATORY THERAPY	.461513		.461513		
50 PHYSICAL THERAPY	.656822		.656822		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.959335		.959335		
55 30 IMPL. DEV. CHARGED TO PATIENT	.077617		.077617		
56 DRUGS CHARGED TO PATIENTS	.429012		.429012		
59 ONCOLOGY	.577415		.577415		
OUTPAT SERVICE COST CNTRS					
60 CLINIC	.535959		.535959		
61 EMERGENCY	.669064		.669064		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.562023		1.562023		
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES	.828739		.828739		
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		1,344,616			
40 ANESTHESIOLOGY		26,272			
41 RADIOLOGY-DIAGNOSTIC		3,998,148			
44 LABORATORY		4,086,851			
49 RESPIRATORY THERAPY		496,119			
50 PHYSICAL THERAPY		471,650			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		281,315			
55 30 IMPL. DEV. CHARGED TO PATIENT		66,296			
56 DRUGS CHARGED TO PATIENTS		1,997,262			
59 ONCOLOGY					
60 OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY		977,785			
62 OBSERVATION BEDS (NON-DISTINCT PART)		494,060			
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES					
101 SUBTOTAL		14,240,374			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		14,240,374			

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII, PART B

HOSPITAL

	All other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
Cost Center Description	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM	333,073		
40 ANESTHESIOLOGY	7,385		
41 RADIOLOGY-DIAGNOSTIC	788,395		
44 LABORATORY	803,042		
49 RESPIRATORY THERAPY	228,965		
50 PHYSICAL THERAPY	309,790		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	269,875		
55 30 IMPL. DEV. CHARGED TO PATIENT	5,146		
56 DRUGS CHARGED TO PATIENTS	856,849		
59 ONCOLOGY			
OUTPAT SERVICE COST CNTRS			
60 CLINIC			
61 EMERGENCY	654,201		
62 OBSERVATION BEDS (NON-DISTINCT PART)	771,733		
63 OTHER OUTPATIENT SERVICE COST CENTER			
63 50 RURAL HEALTH CLINIC			
OTHER REIMBURS COST CNTRS			
65 AMBULANCE SERVICES			
101 SUBTOTAL	5,028,454		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104 NET CHARGES	5,028,454		

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic	All Other (1)
	1	2	3	4	5
(A) ANCILLARY SRVC COST CNTRS					592,597
37 OPERATING ROOM	.247709				161,193
40 ANESTHESIOLOGY	.281089				1,640,879
41 RADIOLOGY-DIAGNOSTIC	.197190				965,699
44 LABORATORY	.196494				171,696
49 RESPIRATORY THERAPY	.461513				130,889
50 PHYSICAL THERAPY	.656822				144,252
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.959335				
55 30 IMPL. DEV. CHARGED TO PATIENT	.077617				537,047
56 DRUGS CHARGED TO PATIENTS	.429012				143,759
59 ONCOLOGY	.577415				
OUTPAT SERVICE COST CNTRS					17,957
60 CLINIC	.535959				807,940
61 EMERGENCY	.669064				
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.562023				
63 OTHER OUTPATIENT SERVICE COST CENTER					146,094
63 50 RURAL HEALTH CLINIC	.859566				
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES	.828739				5,460,002
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					5,460,002
104 NET CHARGES					

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

TITLE XIX - O/P

HOSPITAL

	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy
Cost Center Description	5.01	5.02	5.03	6	7
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC					
44 LABORATORY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
55 30 IMPL. DEV. CHARGED TO PATIENT					
56 DRUGS CHARGED TO PATIENTS					
59 ONCOLOGY					
60 OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY					
62 OBSERVATION BEDS (NON-DISTINCT PART)					
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
63 50 OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES					

TITLE XIX - O/P

HOSPITAL

		Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
Cost Center Description		8	9	9.01	9.02	9.03
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		146,792			
40	ANESTHESIOLOGY		45,310			
41	RADIOLOGY-DIAGNOSTIC		323,565			
44	LABORATORY		189,754			
49	RESPIRATORY THERAPY		79,240			
50	PHYSICAL THERAPY		85,971			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		138,386			
55	30 IMPL. DEV. CHARGED TO PATIENT					
56	DRUGS CHARGED TO PATIENTS		230,400			
59	ONCOLOGY		83,009			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC		9,624			
61	EMERGENCY		540,564			
62	OBSERVATION BEDS (NON-DISTINCT PART)					
63	OTHER OUTPATIENT SERVICE COST CENTER					
63	50 RURAL HEALTH CLINIC		125,577			
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL		1,998,192			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES		1,998,192			

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,611
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,222
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,222
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	317
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	72
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,973
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	317
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	90.06
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	90.06
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	4,166,467
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	6,484
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	379,108
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,787,359

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,504,356
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,504,356
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.080757
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,087.63
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3,787,359

TITLE XVIII PART A

HOSPITAL

OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE  
 PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM					1,175.47
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					2,319,202
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					2,319,202

	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	592,536	97	6,108.62	45	274,888
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				
					1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				
49	TOTAL PROGRAM INPATIENT COSTS				

1,968,857  
 4,562,947

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)	372,624
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	372,624
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 5/16/2011  
 I 14-1327 I FROM 1/ 1/2010 I WORKSHEET D-1  
 I COMPONENT NO: I TO 12/31/2010 I PART III  
 I 14-1327 I I

TITLE XVIII PART A

HOSPITAL

OTHER

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

1

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

PART IV - COMPUTATION OF OBSERVATION BED COST

- 83 TOTAL OBSERVATION BED DAYS 682
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 1,175.47
- 85 OBSERVATION BED COST 801,671

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,611
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,222
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,222
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	317
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	72
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)	94
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	72
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	90.00
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	90.00
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	
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	6,480
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	5,900
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	-5,900

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,504,356
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,504,356
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	- .001684
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,087.63
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	-5,900

TITLE XIX - I/P HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE  
 PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	-	1.83
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST		-172
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM		
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST		-172

	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		97		6	
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				
					1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				
49	TOTAL PROGRAM INPATIENT COSTS				
					148,647
					148,475

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		148,475

TARGET AMOUNT AND LIMIT COMPUTATION

37

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	6,480
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	6,480

TITLE XIX - I/P HOSPITAL OTHER

PART III - SKILLED NURSING FACILITY, NURSING FACILITY & ICF/MR ONLY 1

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BED DAYS 682  
 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM - 1.83  
 85 OBSERVATION BED COST -1,248

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 HOSPITAL OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		1,879,963	
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS		70,088	
37	OPERATING ROOM	.247709	1,448,055	358,696
40	ANESTHESIOLOGY	.281089	7,875	2,214
41	RADIOLOGY-DIAGNOSTIC	.197190	410,822	81,010
44	LABORATORY	.196494	645,362	126,810
49	RESPIRATORY THERAPY	.461513	330,799	152,668
50	PHYSICAL THERAPY	.656822	166,545	109,390
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.959335	619,128	593,951
55	30 IMPL. DEV. CHARGED TO PATIENT	.077617	1,143,353	88,744
56	DRUGS CHARGED TO PATIENTS	.429012	1,060,366	454,910
59	ONCOLOGY OUTPAT SERVICE COST CNTRS	.577415		
60	CLINIC	.535959		
61	EMERGENCY	.669064	694	464
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.562023		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		5,832,999	1,968,857
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		5,832,999	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

TITLE XVIII, PART A SWING BED SNF OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.247709	29	7
40	ANESTHESIOLOGY	.281089		
41	RADIOLOGY-DIAGNOSTIC	.197190	29,142	5,747
44	LABORATORY	.196494	43,425	8,533
49	RESPIRATORY THERAPY	.461513	35,523	16,394
50	PHYSICAL THERAPY	.656822	60,527	39,755
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.959335	38,967	37,382
55	30 IMPL. DEV. CHARGED TO PATIENT	.077617		
56	DRUGS CHARGED TO PATIENTS	.429012	137,798	59,117
59	ONCOLOGY	.577415		
60	OUTPAT SERVICE COST CNTRS CLINIC	.535959		
61	EMERGENCY	.669064		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.562023		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC			
65	OTHER REIMBURS COST CNTRS AMBULANCE SERVICES			
101	TOTAL		345,411	166,935
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		345,411	

TITLE XIX HOSPITAL OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		164,589	
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS		5,063	
37	OPERATING ROOM	.247709	94,150	23,322
40	ANESTHESIOLOGY	.281089	28,497	8,010
41	RADIOLOGY-DIAGNOSTIC	.197190	37,583	7,411
44	LABORATORY	.196494	35,068	6,891
49	RESPIRATORY THERAPY	.461513	19,134	8,831
50	PHYSICAL THERAPY	.656822	2,442	1,604
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.959335	63,408	60,830
55	30 IMPL. DEV. CHARGED TO PATIENT	.077617		
56	DRUGS CHARGED TO PATIENTS	.429012	70,361	30,186
59	ONCOLOGY OUTPAT SERVICE COST CNTRS	.577415		
60	CLINIC	.535959		
61	EMERGENCY	.669064	2,335	1,562
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.562023		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS	.859566		
65	AMBULANCE SERVICES			
101	TOTAL		352,978	148,647
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		352,978	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
 I 14-1327 I FROM 1/ 1/2010 I WORKSHEET E  
 I COMPONENT NO: I TO 12/31/2010 I PART B  
 I 14-1327 I I

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) 5,028,454  
 1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1,  
 2001 (SEE INSTRUCTIONS).  
 1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.  
 1.03 ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.  
 1.04 LINE 1.01 TIMES LINE 1.03.  
 1.05 LINE 1.02 DIVIDED BY LINE 1.04.  
 1.06 TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)  
 1.07 OUTPATIENT ANCILLARY PASSTHRU COSTS FROM (W/S D,IV  
 (COLS 9, 9.01, 9.02) LINE 101  
 2 INTERNS AND RESIDENTS  
 3 ORGAN ACQUISITIONS  
 4 COST OF TEACHING PHYSICIANS  
 5 TOTAL COST (SEE INSTRUCTIONS) 5,028,454

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) 5,078,739  
 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18 CAH DEDUCTIBLES 36,593  
 18.01 CAH ACTUAL BILLED COINSURANCE 2,057,360  
 LINE 17.01 (SEE INSTRUCTIONS)  
 19 SUBTOTAL (SEE INSTRUCTIONS) 2,984,786  
 20 SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)  
 21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS  
 22 ESRD DIRECT MEDICAL EDUCATION COSTS  
 23 SUBTOTAL 2,984,786  
 24 PRIMARY PAYER PAYMENTS 479  
 25 SUBTOTAL 2,984,307  
 REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)  
 26 COMPOSITE RATE ESRD  
 27 BAD DEBTS (SEE INSTRUCTIONS) 308,547  
 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) 308,547  
 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES  
 28 SUBTOTAL 3,292,854  
 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 3,292,854  
 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)  
 34 INTERIM PAYMENTS 3,149,727  
 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)  
 35 BALANCE DUE PROVIDER/PROGRAM 143,127  
 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 5/16/2011  
 I 14-1327 I FROM 1/ 1/2010 I WORKSHEET E-1  
 I COMPONENT NO: I TO 12/31/2010 I  
 I 14-1327 I I

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3,773,406		2,492,107
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 12/17/2010	69,044	6/29/2010	178,330
ADJUSTMENTS TO PROVIDER	.02		12/17/2010	269,633
ADJUSTMENTS TO PROVIDER	.03		12/17/2010	209,657
ADJUSTMENTS TO PROVIDER	.04			
ADJUSTMENTS TO PROVIDER	.05			
ADJUSTMENTS TO PROVIDER	.49			
ADJUSTMENTS TO PROGRAM	.50 12/27/2010	100,802		
ADJUSTMENTS TO PROGRAM	.51 6/29/2010	113		
ADJUSTMENTS TO PROGRAM	.52			
ADJUSTMENTS TO PROGRAM	.53			
ADJUSTMENTS TO PROGRAM	.54			
SUBTOTAL	.99	-31,871		657,620
4 TOTAL INTERIM PAYMENTS		3,741,535		3,149,727
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	SETTLEMENT TO PROVIDER	.01 498,570		143,127
AMOUNT (BALANCE DUE)	SETTLEMENT TO PROGRAM	.02		
BASED ON COST REPORT (1)				
7 TOTAL MEDICARE PROGRAM LIABILITY		4,240,105		3,292,854

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.

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		443,996		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER	.01	6/29/2010	7,552	
ADJUSTMENTS TO PROVIDER	.02	12/27/2010	6,400	
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		13,952	NONE
4 TOTAL INTERIM PAYMENTS			457,948	
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)			83,981	
7 TOTAL MEDICARE PROGRAM LIABILITY			541,929	

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 14-1327 I FROM 1/ 1/2010 I  
 I COMPONENT NO: I TO 12/31/2010 I WORKSHEET E-2  
 I 14-Z327 I I

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	376,350	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	168,604	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	317	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	544,954	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	544,954	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	544,954	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS) (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	3,025	
14	80% OF PART B COSTS		
15	SUBTOTAL	541,929	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	541,929	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	457,948	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	83,981	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT  
SWING BEDS

I PROVIDER NO: I PERIOD: I  
I 14-1327 I FROM 1/ 1/2010 I  
I COMPONENT NO: I TO 12/31/2010 I WORKSHEET E-2  
I 14-Z327 I I

TITLE XIX 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
I	14-1327	I	FROM 1/ 1/2010	I	5/16/2011
I	COMPONENT NO:	I	TO 12/31/2010	I	WORKSHEET E-3
I	14-1327	I		I	PART II

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	4,562,947
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	4,562,947
5	PRIMARY PAYER PAYMENTS	8,318
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	4,600,175
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	4,600,175
19	COST OF COVERED SERVICES	409,111
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	
21	EXCESS REASONABLE COST	
22	SUBTOTAL	4,191,064
23	COINSURANCE	2,200
24	SUBTOTAL	4,188,864
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	51,241
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	51,241
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
26	SUBTOTAL	4,240,105
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	4,240,105
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	3,741,535
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	498,570
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	3,878,326			
2 TEMPORARY INVESTMENTS	4,355,260			
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	4,225,788			
5 OTHER RECEIVABLES	1,036,430			
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7 INVENTORY	597,518			
8 PREPAID EXPENSES				
9 OTHER CURRENT ASSETS	845,146			
10 DUE FROM OTHER FUNDS				
11 TOTAL CURRENT ASSETS	14,938,468			
FIXED ASSETS				
12 LAND				
12.01 LAND IMPROVEMENTS				
13.01 LESS ACCUMULATED DEPRECIATION				
14 BUILDINGS	27,370,463			
14.01 LESS ACCUMULATED DEPRECIATION	-15,845,165			
15 LEASEHOLD IMPROVEMENTS				
15.01 LESS ACCUMULATED DEPRECIATION				
16 FIXED EQUIPMENT				
16.01 LESS ACCUMULATED DEPRECIATION				
17 AUTOMOBILES AND TRUCKS				
17.01 LESS ACCUMULATED DEPRECIATION				
18 MAJOR MOVABLE EQUIPMENT				
18.01 LESS ACCUMULATED DEPRECIATION				
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE				
21 TOTAL FIXED ASSETS	11,525,298			
OTHER ASSETS				
22 INVESTMENTS				
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS	4,401,246			
26 TOTAL OTHER ASSETS	4,401,246			
27 TOTAL ASSETS	30,865,012			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	662,184			
29 SALARIES, WAGES & FEES PAYABLE	800,264			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	1,734,284			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	699,240			
36 TOTAL CURRENT LIABILITIES	3,895,972			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE	9,057,668			
38 NOTES PAYABLE				
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES				
42 TOTAL LONG-TERM LIABILITIES	9,057,668			
43 TOTAL LIABILITIES	12,953,640			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	17,911,372			
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	17,911,372			
52 TOTAL LIABILITIES AND FUND BALANCES	30,865,012			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		11,527,192		
2 NET INCOME (LOSS)		1,813,409		
3 TOTAL		13,340,601		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADDITIONS (CREDIT ADJUSTM	4,570,771			
6				
7				
8				
9				
10 TOTAL ADDITIONS		4,570,771		
11 SUBTOTAL		17,911,372		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM				
14				
15				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		17,911,372		

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
 I 14-1327 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	3,504,356		3,504,356
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	3,504,356		3,504,356
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT	113,050		113,050
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	113,050		113,050
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	3,617,406		3,617,406
17 00 ANCILLARY SERVICES	9,285,864	34,345,805	43,631,669
18 00 OUTPATIENT SERVICES			
18 50 RURAL HEALTH CLINIC		384,464	384,464
20 00 AMBULANCE SERVICES		1,241,978	1,241,978
24 00 PHYSICIAN	46,798	7,860,190	7,906,988
25 00 TOTAL PATIENT REVENUES	12,950,068	43,832,437	56,782,505

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		27,052,336	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)	506		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		506	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		27,052,842	

STATEMENT OF REVENUES AND EXPENSES

PROVIDER NO: 14-1327  
 PERIOD: FROM 1/1/2010 TO 12/31/2010  
 PREPARED 5/16/2011  
 WORKSHEET G-3

DESCRIPTION

1	TOTAL PATIENT REVENUES	56,782,505
2	LESS: ALLOWANCES AND DISCOUNTS ON	29,093,893
3	NET PATIENT REVENUES	27,688,612
4	LESS: TOTAL OPERATING EXPENSES	27,052,842
5	NET INCOME FROM SERVICE TO PATIENT	635,770
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER REV	607,070
24.01	NON OPERATING REV	570,569
25	TOTAL OTHER INCOME	1,177,639
26	TOTAL	1,813,409
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIO	1,813,409

RHC 1

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1				
2	91,398		91,398	
3	14,324		14,324	
4				
5	56,624		56,624	
6				
7				
8				
9				
10	162,346		162,346	
COSTS UNDER AGREEMENT				
11				
12				
13				
14				
OTHER HEALTH CARE COSTS				
15		3,326	3,326	
16				
17				
18				
19				
20				
21		3,326	3,326	
22	162,346	3,326	165,672	
COSTS OTHER THAN RHC/FQHC SERVICES				
23				
24				
25				
26				
27				
28				
FACILITY OVERHEAD				
29				
30	8,922	2,763	11,685	-1,819
31	8,922	2,763	11,685	-1,819
32	171,268	6,089	177,357	-1,819

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/  
FEDERALLY QUALIFIED HEALTH CENTER COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
I 14-1327 I FROM 1/ 1/2010 I WORKSHEET M-1  
I COMPONENT NO: I TO 12/31/2010 I  
I 14-8501 I I

RHC 1

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
FACILITY HEALTH CARE STAFF COSTS			
1			
2	91,398		91,398
3	14,324		14,324
4			
5	56,624		56,624
6			
7			
8			
9			
10	162,346		162,346
COSTS UNDER AGREEMENT			
11			
12			
13			
14			
OTHER HEALTH CARE COSTS			
15	3,326		3,326
16			
17			
18			
19			
20			
21	3,326		3,326
22	165,672		165,672
COSTS OTHER THAN RHC/FQHC SERVICES			
23			
24			
25			
26			
27			
28			
FACILITY OVERHEAD			
29			
30	9,866		9,866
31	9,866		9,866
32	175,538		175,538

ALLOCATION OF OVERHEAD  
TO RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
I 14-1327 I FROM 1/ 1/2010 I WORKSHEET M-2  
I COMPONENT NO: I TO 12/31/2010 I  
I 14-8501 I I

RHC 1

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
POSITIONS				
1 PHYSICIANS	.01	13	4,200	42
2 PHYSICIAN ASSISTANTS			2,100	
3 NURSE PRACTITIONERS	.98	4,801	2,100	2,058
4 SUBTOTAL (SUM OF LINES 1-3)	.99	4,814		2,100
5 VISITING NURSE				
6 CLINICAL PSYCHOLOGIST				
7 CLINICAL SOCIAL WORKER				
8 TOTAL FTES AND VISITS (SUM OF LINES 4-7)	.99	4,814		
9 PHYSICIAN SERVICES UNDER AGREEMENTS				
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10 TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	165,672			
11 TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)				
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	165,672			
13 RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000			
14 TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	9,866			
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	154,934			
16 TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	164,800			
17 ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)				
18 SUBTRACT LINE 17 FROM LINE 16	164,800			
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	164,800			
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	330,472			
	GREATER OF COL. 2 OR COL. 4 5			
POSITIONS				
1 PHYSICIANS				
2 PHYSICIAN ASSISTANTS				
3 NURSE PRACTITIONERS				
4 SUBTOTAL (SUM OF LINES 1-3)	4,814			
5 VISITING NURSE				
6 CLINICAL PSYCHOLOGIST				
7 CLINICAL SOCIAL WORKER				
8 TOTAL FTES AND VISITS (SUM OF LINES 4-7)	4,814			
9 PHYSICIAN SERVICES UNDER AGREEMENTS				

(1) THE PRODUCTIVITY STANDARD FOR PHYSICIANS IS 4,200 AND 2,100 FOR ALL OTHERS. IF AN EXCEPTION TO THE STANDARD HAS BEEN GRANTED (WORKSHEET S-8, LINE 13 EQUALS "Y"), COLUMN 3, LINES 1 THRU 3 OF THIS WORKSHEET SHOULD BE BLANK. THIS APPLIES TO RHC ONLY.

CALCULATION OF REIMBURSEMENT SETTLEMENT  
FOR RHC/FQHC SERVICES

I PROVIDER NO:	I PERIOD:	I PREPARED
I 14-1327	I FROM 1/ 1/2010	I 5/16/2011
I COMPONENT NO:	I TO 12/31/2010	I WORKSHEET M-3
I 14-8501	I	I

TITLE XVIII RHC 1

1	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	
	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	330,472
	(FROM WORKSHEET M-2, LINE 20)	
2	COST OF VACCINES AND THEIR ADMINISTRATION	
	(FROM WORKSHEET M-4, LINE 15)	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	330,472
	(LINE 1 MINUS LINE 2)	
4	TOTAL VISITS	4,814
	(FROM WORKSHEET M-2, COLUMN 5, LINE 8)	
5	PHYSICIANS VISITS UNDER AGREEMENT	
	(FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	4,814
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	68.65

CALCULATION OF LIMIT (1)

	PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	999.00
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	68.65
10	CALCULATION OF SETTLEMENT	
	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	284
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	19,497
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)	
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)	
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)	
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*	19,497
16.01	PRIMARY PAYER AMOUNT	
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)	2,678
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)	16,819
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)	13,455
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)	
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)	13,455
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	
23	OTHER ADJUSTMENTS (SPECIFY)	
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)	13,455
25	INTERIM PAYMENTS	13,579
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)	-124
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2	

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDER YEAR PROVIDERS USE COLUMN 2 ONLY.

\* FOR LINE 15, USE COLUMN 2 ONLY FOR GRADUATE MEDICAL EDUCATION PASS THROUGH COST.

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES  
 RHC  FQHC

I PROVIDER NO: I PERIOD: I PREPARED 5/16/2011  
 I 14-1327 I FROM 1/ 1/2010 I WORKSHEET M-5  
 I COMPONENT NO: I TO 12/31/2010 I  
 I 14-8501 I

RHC 1

DESCRIPTION		P A R T	
		MM/DD/YYYY	B AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1	2
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
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
ADJUSTMENTS TO PROVIDER	.01	6/29/2010	1,609
ADJUSTMENTS TO PROVIDER	.02		
ADJUSTMENTS TO PROVIDER	.03		
ADJUSTMENTS TO PROVIDER	.04		
ADJUSTMENTS TO PROVIDER	.05		
ADJUSTMENTS TO PROGRAM	.50		
ADJUSTMENTS TO PROGRAM	.51		
ADJUSTMENTS TO PROGRAM	.52		
ADJUSTMENTS TO PROGRAM	.53		
ADJUSTMENTS TO PROGRAM	.54		
ADJUSTMENTS TO PROGRAM	.99		
SUBTOTAL			1,609
4 TOTAL INTERIM PAYMENTS			13,579
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		
TENTATIVE TO PROGRAM	.99		
SUBTOTAL			NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01 SETTLEMENT TO PROGRAM .02		124
7 TOTAL MEDICARE PROGRAM LIABILITY			13,455

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.