REPORT
ON THE
COST REPORT REVIEW

SOUTHERN INYO HOSPITAL
LONE PINE, CALIFORNIA
PROVIDER NUMBERS: ZZT30388F AND LTC55527F
NPI NUMBER: 1831128602

FISCAL PERIOD ENDED
JUNE 30, 2008

Audits Section—Fresno
Financial Audits Branch
Audits and Investigations
Department of Health Care Services

Section Chief: Michael Harrold
Audit Supervisor: Kristina Nacino
Auditors: Lisa Merrill and Paul Vandrick

State of California—Health and Human Services Agency
Department of Health Care Services

DAVID MAXWELL-JOLLY
Director

ARNOLD SCHWARZENEGGER
Governor

April 7, 2010

Lee Barron. CEO
Southern Inyo Hospital
P.O. Box 1009
Lone Pine, CA 93545

PROVIDER: SOUTHERN INYO HOSPITAL
PROVIDER NO. ZZT30388F
NPI NO. 1831128602
FISCAL PERIOD ENDED JUNE 30, 2008

We have examined the provider's Medi-Cal Cost Report for the above-referenced fiscal period. Our examination was made under the authority of Section 14170 of the Welfare and Institutions Code and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the audited settlement for the fiscal period due the State in the amount of $5,652 presented in the Summary of Findings represents a proper determination in accordance with the reimbursement principles of applicable programs.

This audit report includes the:

1. Summary of Findings

2. Computation of Medi-Cal Reimbursement Settlement (NONCONTRACT Schedules)

3. Computation of Distinct Part Nursing Facility Per Diem (DPNF Schedules)

4. Audit Adjustments Schedule

The audited settlement will be incorporated into a Statement of Account Status, which may reflect tentative retroactive adjustment determinations, payments from the provider, and other financial transactions initiated by the Department. The Statement of Account Status will be forwarded to the provider by the State's fiscal intermediary. Instructions regarding payment will be included with the Statement of Account Status.

Future Distinct Part Nursing Facility prospective rates may be affected by this examination. The extent of the rate changes will be determined by the Department's Rate Development Branch.

Notwithstanding this audit report, overpayments to the provider are subject to recovery pursuant to Section 51458.1, Article 6 of Division 3, Title 22, California Code of Regulations.

If you disagree with the decision of the Department, you may appeal by writing to:

Chief
Office of Administrative Appeals and Hearings
1029 J Street, Suite 200
Sacramento, CA 95814
(916) 322-5603

The written notice of disagreement must be received by the Department within 60 calendar days from the day you receive this letter. A copy of this notice should be sent to:

United States Postal Service (USPS)
Assistant Chief Counsel
Department of Health Care Services
Office of Legal Services
MS 0010
PO Box 997413
Sacramento, CA 95899-7413

Courier (UPS, FedEx, etc.)
Assistant Chief Counsel
Department of Health Care Services
Office of Legal Services
MS 0010
1501 Capitol Avenue, Suite 71.5001
Sacramento, CA 95814-5005
(916) 440-7700

The procedures that govern an appeal are contained in Welfare and Institutions Code, Section 14171, and California Code of Regulations, Title 22, Section 51016, et seq.

If you have questions regarding this report, you may call the Audits Section—Fresno at (559) 446-2458.

Original Signed by

Michael A. Harrold, Chief
Audits Section—Fresno
Financial Audits Branch

Certified

SUMMARY OF FINDINGS

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

		SETTLEMENT	COST
1.	**Medi-Cal Noncontract Settlement (SCHEDULE 1)** **Provider No. ZZT30388F**		
	Reported	$ 1,501	
	Net Change	$ (595)	
	Audited Amount Due Provider (State)	$ 906	
2.	**Subprovider I (SCHEDULE 1-1)** **Provider No.**		
	Reported	$ 0	
	Net Change	$ 0	
	Audited Amount Due Provider (State)	$ 0	
3.	**Subprovider II (SCHEDULE 1-2)** **Provider No.**		
	Reported	$ 0	
	Net Change	$ 0	
	Audited Amount Due Provider (State)	$ 0	
4.	**Medi-Cal Contract Cost (CONTRACT SCH 1)** **Provider No.**		
	Reported		$ 0
	Net Change		$ 0
	Audited Cost		$ 0
	Audited Amount Due Provider (State)	$ 0	
5.	**Distinct Part Nursing Facility (DPNF SCH 1)** **Provider No. LTC55527F**		
	Reported		$ 208.95
	Net Change		$ (6.73)
	Audited Cost Per Day		$ 202.22
	Audited Amount Due Provider (State)	$ (6,558)	
6.	**Distinct Part Nursing Facility (DPNF SCH 1-1)** **Provider No.**		
	Reported		$ 0.00
	Net Change		$ 0.00
	Audited Cost Per Day		$ 0.00
	Audited Amount Due Provider (State)	$ 0	
7.	**Adult Subacute (ADULT SUBACUTE SCH 1)** **Provider No.**		
	Reported		$ 0.00
	Net Change		$ 0.00
	Audited Cost Per Day		$ 0.00
	Audited Amount Due Provider (State)	$ 0	
8.	**Total Medi-Cal Settlement** **Due Provider (State) - (Lines 1 through 7)**	$ (5,652)	
9.	**Total Medi-Cal Cost**		$ 0

SUMMARY OF FINDINGS

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

		SETTLEMENT	COST
10.	**Subacute (SUBACUTE SCH 1-1)**		
	Provider No.		
	Reported		$ 0.00
	Net Change		$ 0.00
	Audited Cost Per Day		$ 0.00
	Audited Amount Due Provider (State)	$ 0	
11.	**Rural Health Clinic (RHC SCH 1)**		
	Provider No.		
	Reported	$ 0	
	Net Change	$ 0	
	Audited Amount Due Provider (State)	$ 0	
12.	**Rural Health Clinic (RHC 95-210 SCH 1)**		
	Provider No.		
	Reported	$ 0	
	Net Change	$ 0	
	Audited Amount Due Provider (State)	$ 0	
13.	**Rural Health Clinic (RHC 95-210 SCH 1-1)**		
	Provider No.		
	Reported	$ 0	
	Net Change	$ 0	
	Audited Amount Due Provider (State)	$ 0	
14.	**County Medical Services Program (CMSP SCH 1)**		
	Provider No.		
	Reported	$ 0	
	Net Change	$ 0	
	Audited Amount Due Provider (State)	$ 0	
15.	**Transitional Care (TC SCH 1)**		
	Provider No.		
	Reported		$ 0.00
	Net Change		$ 0.00
	Audited Cost Per Day		$ 0.00
	Audited Amount Due Provider (State)	$ 0	
16.	**Total Other Settlement Due Provider - (Lines 10 through 15)**	$ 0	
17.	**Total Combined Audited Settlement Due Provider (State/CMSP/RHC) - (Line 8 + Line 16)**	$ (5,652)	

STATE OF CALIFORNIA

SCHEDULE 1
PROGRAM: NONCONTRACT

COMPUTATION OF MEDI-CAL REIMBURSEMENT SETTLEMENT

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

Provider No.
ZZT30388F

		REPORTED	AUDITED
1.	Net Cost of Covered Services Rendered to Medi-Cal Patients (Schedule 3)	$ 2,068	$ 2,516
2.	Excess Reasonable Cost Over Charges (Schedule 2)	$ 0	$ (504)
3.	Medi-Cal Inpatient Hospital Based Physician Services	$ 539	$ N/A
4.		$ 0	$ 0
5.	TOTAL COST-Reimbursable to Provider (Lines 1 through 4)	$ 2,607	$ 2,012
6.	Interim Payments (Adj)	$ (1,106)	$ (1,106)
7.	Balance Due Provider (State)	$ 1,501	$ 906
8.	Duplicate Payments (Adj)	$ 0	$ 0
9.		$ 0	$ 0
10.		$ 0	$ 0
11.	TOTAL MEDI-CAL SETTLEMENT Due Provider (State)	$ 1,501	$ 906

(To Summary of Findings)

STATE OF CALIFORNIA

SCHEDULE 2
PROGRAM: NONCONTRACT

COMPUTATION OF LESSER OF
MEDI-CAL REASONABLE COST OR CUSTOMARY CHARGES

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

Provider No.
ZZT30388F

	REPORTED	AUDITED
REASONABLE COST OF MEDI-CAL INPATIENT SERVICES		
1. Cost of Covered Services (Schedule 3)	$ 2,068	$ 2,516
CHARGES FOR MEDI-CAL INPATIENT SERVICES		
2. Inpatient Routine Service Charges (Adj)	$ 545	$ 545
3. Inpatient Ancillary Service Charges (Adj)	$ 1,467	$ 1,467
4. Total Charges - Medi-Cal Inpatient Services	$ 2,012	$ 2,012
5. Excess of Customary Charges Over Reasonable Cost (Line 4 minus Line 1) *	$ 0	$ 0
6. Excess of Reasonable Cost Over Customary Charges (Line 1 minus Line 4)	$ 56	$ 504

(To Schedule 1)

* If charges exceed reasonable cost, no further calculation necessary for this schedule.

STATE OF CALIFORNIA

SCHEDULE 3
PROGRAM: NONCONTRACT

COMPUTATION OF
MEDI-CAL NET COSTS OF COVERED SERVICES

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

Provider No.
ZZT30388F

		REPORTED	AUDITED
1.	Medi-Cal Inpatient Ancillary Services (Schedule 5)	$ 524	$ 527
2.	Medi-Cal Inpatient Routine Services (Schedule 4)	$ 1,544	$ 1,450
3.	Medi-Cal Inpatient Hospital Based Physician for Intern and Resident Services (Sch)	$ 0	$ 0
4.		$ 0	$ 0
5.		$ 0	$ 0
6.	SUBTOTAL (Sum of Lines 1 through 5)	$ 2,068	$ 1,977
7.	Medi-Cal Inpatient Hospital Based Physician for Acute Care Services (Schedule 7)	$ (See Schedule 1)	$ 539
8.	SUBTOTAL	$ 2,068	$ 2,516
		(To Schedule 2)	
9.	Coinsurance (Adj)	$ 0	$ 0
10.	Patient and Third Party Liability (Adj)	$ 0	$ 0
11.	Net Cost of Covered Services Rendered to Medi-Cal Inpatients	$ 2,068	$ 2,516
		(To Schedule 1)	

STATE OF CALIFORNIA

SCHEDULE 4
PROGRAM: NONCONTRACT

COMPUTATION OF
MEDI-CAL INPATIENT ROUTINE SERVICE COST

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

Provider No.
ZZT30388F

GENERAL SERVICE UNIT NET OF SWING-BED COSTS		REPORTED		AUDITED
INPATIENT DAYS				
1. Total Inpatient Days (include private & swing-bed) (Adj 11)		178		200
2. Inpatient Days (include private, exclude swing-bed)		44		44
3. Private Room Days (exclude swing-bed private room) (Adj)		0		0
4. Semi-Private Room Days (exclude swing-bed) (Adj)		44		44
5. Medicare NF Swing-Bed Days through Dec 31 (Adj 12)		0		55
6. Medicare NF Swing-Bed Days after Dec 31 (Adj 12)		82		27
7. Medi-Cal NF Swing-Bed Days through July 31 (Adj 14)		0		11
8. Medi-Cal NF Swing-Bed Days after July 31 (Adj 14)		52		63
9. Medi-Cal Days (excluding swing-bed) (Adj)		1		1
SWING-BED ADJUSTMENT				
17. Medicare NF Swing-Bed Rates through Dec 31 (Adj 13)	$	0.00	$	1,450.07
18. Medicare NF Swing-Bed Rates after Dec 31 (Adj 13)	$	0.00	$	1,450.07
19. Medi-Cal NF Swing-Bed Rates through July 31(Adj 15)	$	144.66	$	269.26
20. Medi-Cal NF Swing-Bed Rates after July 31(Adj 15)	$	144.66	$	285.31
21. Total Routine Serv Cost (Sch 8, Line 25, Col 27)	$	202,049	$	203,645
22. Medicare NF Swing-Bed Cost through Dec 31 (L 5 x L 17)	$	0	$	79,754
23. Medicare NF Swing-Bed Cost after Dec 31 (L 6 x L 18)	$	0	$	39,152
24. Medi-Cal NF Swing-Bed Cost through July 31 (L 7 x L 19)	$	0	$	2,962
25. Medi-Cal NF Swing-Bed Cost after July 31 (L 8 x L 20)	$	7,522	$	17,975
26. Total Swing-Bed Cost (Sum of Lines 22 to 25)	$	134,119	$	139,842
27. Inpatient Routine Cost Net of Swing-Bed (L 21 minus L 26)	$	67,930	$	63,803
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. Gen Inpatient Routine Serv Charges (excl swing-bed charges)	$	51,480	$	51,480
29. Private Room Charges (excluding swing-bed charges)	$	0	$	0
30. Semi-Private Room Charges (excluding swing-bed charges)	$	51,480	$	51,480
31. Gen Inpatient Routine Service Cost/Charge Ratio (L 27 / L 28)	$	1.319542	$	1.239374
32. Average Private Room Per Diem Charge (L 29 / L 3)	$	0.00	$	0.00
33. Average Semi-Private Room Per Diem Charge (L 30 / L 4)	$	1,170.00	$	1,170.00
34. Avg Per Diem Prvt Room Charge Differential (L 32 minus L 33)	$	0.00	$	0.00
35. Average Per Diem Private Room Cost Differential (L 31 x L 34)	$	0.00	$	0.00
36. Private Room Cost Differential Adjustment (L 35 x L 3)	$	0	$	0
37. Inpatient Rout Cost Net of Swing-Bed & Prvt Rm (L 27 minus L 36)	$	67,930	$	63,803
PROGRAM INPATIENT OPERATING COST				
38. Adjusted General Inpatient Routine Cost Per Diem (L 37 / L 2)	$	1,543.86	$	1,450.07
39. Program General Inpatient Routine Service Cost (L 9 x L 38)	$	1,544	$	1,450
40. Cost Applicable to Medi-Cal (Sch 4A)	$	0	$	0
41. Cost Applicable to Medi-Cal (Sch 4B)	$	0	$	0
42. TOTAL MEDI-CAL ROUTINE COST (Sum of Lines 39,40 & 41)	$	1,544	$	1,450

(To Schedule 3)

STATE OF CALIFORNIA

SCHEDULE 4A
PROGRAM: NONCONTRACT

COMPUTATION OF
MEDI-CAL INPATIENT ROUTINE SERVICE COST

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

Provider No.
ZZT30388F

SPECIAL CARE AND/OR NURSERY UNITS	REPORTED	AUDITED
NURSERY		
1. Total Inpatient Routine Cost (Sch 8, Line 33, Col 27)	$ 0	$ 0
2. Total Inpatient Days (Adj)	0	0
3. Average Per Diem Cost	$ 0.00	$ 0.00
4. Medi-Cal Inpatient Days (Adj)	0	0
5. Cost Applicable to Medi-Cal	$ 0	$ 0
INTENSIVE CARE UNIT		
6. Total Inpatient Routine Cost (Sch 8, Line 26, Col 27)	$ 0	$ 0
7. Total Inpatient Days (Adj)	0	0
8. Average Per Diem Cost	$ 0.00	$ 0.00
9. Medi-Cal Inpatient Days (Adj)	0	0
10. Cost Applicable to Medi-Cal	$ 0	$ 0
CORONARY CARE UNIT		
11. Total Inpatient Routine Cost (Sch 8, Line 27, Col 27)	$ 0	$ 0
12. Total Inpatient Days (Adj)	0	0
13. Average Per Diem Cost	$ 0.00	$ 0.00
14. Medi-Cal Inpatient Days (Adj)	0	0
15. Cost Applicable to Medi-Cal	$ 0	$ 0
NEONATAL INTENSIVE CARE UNIT		
16. Total Inpatient Routine Cost (Sch 8, Line 28, Col 27)	$ 0	$ 0
17. Total Inpatient Days (Adj)	0	0
18. Average Per Diem Cost	$ 0.00	$ 0.00
19. Medi-Cal Inpatient Days (Adj)	0	0
20. Cost Applicable to Medi-Cal	$ 0	$ 0
SURGICAL INTENSIVE CARE UNIT		
21. Total Inpatient Routine Cost (Sch 8, Line 29, Col 27)	$ 0	$ 0
22. Total Inpatient Days (Adj)	0	0
23. Average Per Diem Cost	$ 0.00	$ 0.00
24. Medi-Cal Inpatient Days (Adj)	0	0
25. Cost Applicable to Medi-Cal	$ 0	$ 0
ADMINISTRATIVE DAYS		
26. Per Diem Rate (Adj)	$ 0.00	$ 0.00
27. Medi-Cal Inpatient Days (Adj)	0	0
28. Cost Applicable to Medi-Cal	$ 0	$ 0
ADMINISTRATIVE DAYS		
29. Per Diem Rate (Adj)	$ 0.00	$ 0.00
30. Medi-Cal Inpatient Days (Adj)	0	0
31. Cost Applicable to Medi-Cal	$ 0	$ 0
32. Medi-Cal Routine Cost (Sum of Lines 5,10,15,20,25,28,31)	$ 0	$ 0

(To Schedule 4)

STATE OF CALIFORNIA

SCHEDULE 4B
PROGRAM: NONCONTRACT

COMPUTATION OF
MEDI-CAL INPATIENT ROUTINE SERVICE COST

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

Provider No.
ZZT30388F

	SPECIAL CARE UNITS	REPORTED	AUDITED
1.	Total Inpatient Routine Cost (Sch 8, Line ___, Col 27)	$ 0	$ 0
2.	Total Inpatient Days (Adj)	0	0
3.	Average Per Diem Cost	$ 0.00	$ 0.00
4.	Medi-Cal Inpatient Days (Adj)	0	0
5.	Cost Applicable to Medi-Cal	$ 0	$ 0
6.	Total Inpatient Routine Cost (Sch 8, Line ___, Col 27)	$ 0	$ 0
7.	Total Inpatient Days (Adj)	0	0
8.	Average Per Diem Cost	$ 0.00	$ 0.00
9.	Medi-Cal Inpatient Days (Adj)	0	0
10.	Cost Applicable to Medi-Cal	$ 0	$ 0
11.	Total Inpatient Routine Cost (Sch 8, Line ___, Col 27)	$ 0	$ 0
12.	Total Inpatient Days (Adj)	0	0
13.	Average Per Diem Cost	$ 0.00	$ 0.00
14.	Medi-Cal Inpatient Days (Adj)	0	0
15.	Cost Applicable to Medi-Cal	$ 0	$ 0
16.	Total Inpatient Routine Cost (Sch 8, Line ___, Col 27)	$ 0	$ 0
17.	Total Inpatient Days (Adj)	0	0
18.	Average Per Diem Cost	$ 0.00	$ 0.00
19.	Medi-Cal Inpatient Days (Adj)	0	0
20.	Cost Applicable to Medi-Cal	$ 0	$ 0
21.	Total Inpatient Routine Cost (Sch 8, Line ___, Col 27)	$ 0	$ 0
22.	Total Inpatient Days (Adj)	0	0
23.	Average Per Diem Cost	$ 0.00	$ 0.00
24.	Medi-Cal Inpatient Days (Adj)	0	0
25.	Cost Applicable to Medi-Cal	$ 0	$ 0
26.	Total Inpatient Routine Cost (Sch 8, Line ___, Col 27)	$ 0	$ 0
27.	Total Inpatient Days (Adj)	0	0
28.	Average Per Diem Cost	$ 0.00	$ 0.00
29.	Medi-Cal Inpatient Days (Adj)	0	0
30.	Cost Applicable to Medi-Cal	$ 0	$ 0
31.	Medi-Cal Routine Cost (Sum of Lines 5,10,15,20,25,30)	$ 0	$ 0

(To Schedule 4)

STATE OF CALIFORNIA

SCHEDULE 5
PROGRAM: NONCONTRACT

SCHEDULE OF MEDI-CAL ANCILLARY COSTS

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

Provider No:
ZZT30388F

		TOTAL ANCILLARY COST *	TOTAL ANCILLARY CHARGES (Adj)	RATIO COST TO CHARGES	MEDI-CAL CHARGES (From Schedule 6)	MEDI-CAL COST
ANCILLARY COST CENTERS						
37.00	Operating Room	$ 0	$ 0	0.000000	$ 0	$ 0
38.00	Recovery Room	0	0	0.000000	0	0
39.00	Delivery Room and Labor Room	0	0	0.000000	0	0
40.00	Anesthesiology	0	0	0.000000	0	0
41.00	Radiology - Diagnostic	660,171	1,344,172	0.491136	0	0
41.01		0	0	0.000000	0	0
41.02		0	0	0.000000	0	0
42.00	Radiology - Therapeutic	0	0	0.000000	0	0
43.00	Radioisotope	0	0	0.000000	0	0
44.00	Laboratory	688,791	885,130	0.778181	0	0
44.01	Pathological Lab	0	0	0.000000	0	0
46.00	Whole Blood	10,519	3,094	3.399966	0	0
47.00	Blood Storing and Processing	0	0	0.000000	0	0
48.00	Intravenous Therapy	0	0	0.000000	0	0
49.00	Respiratory Therapy	7,654	183,337	0.041750	392	16
50.00	Physical Therapy	387,844	851,932	0.455253	0	0
51.00	Occupational Therapy	0	0	0.000000	0	0
52.00	Speech Pathology	0	0	0.000000	0	0
53.00	Electrocardiology	0	0	0.000000	0	0
54.00	Electroencephalography	0	0	0.000000	0	0
55.00	Medical Supplies Charged to Patients	192,205	432,006	0.444912	100	44
56.00	Drugs Charged to Patients	69,449	313,012	0.221872	114	25
57.00	Renal Dialysis	0	0	0.000000	0	0
58.00	ASC (Non-Distinct Part)	0	0	0.000000	0	0
59.00		0	0	0.000000	0	0
59.01		0	0	0.000000	0	0
59.02		0	0	0.000000	0	0
59.03		0	0	0.000000	0	0
60.00	Clinic	0	0	0.000000	0	0
60.01	Other Clinic Services	0	0	0.000000	0	0
61.00	Emergency	413,801	806,599	0.513020	861	442
62.00	Observation Beds	0	0	0.000000	0	0
63.00	Med. Transport	17,708	10,866	1.629658	0	0
63.50	Rural Health Clinic	1,165,849	741,218	1.572882	0	0
	TOTAL	$ 3,613,991	$ 5,571,366		$ 1,467	$ 527

(To Schedule 3)

* From Schedule 8, Column 27

STATE OF CALIFORNIA

SCHEDULE 6
PROGRAM: NONCONTRACT

ADJUSTMENTS TO MEDI-CAL CHARGES

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

Provider No:
ZZT30388F

	ANCILLARY CHARGES	REPORTED	ADJUSTMENTS (Adj)	AUDITED
37.00	Operating Room	$	$	$ 0
38.00	Recovery Room			0
39.00	Delivery Room and Labor Room			0
40.00	Anesthesiology			0
41.00	Radiology - Diagnostic			0
41.01				0
41.02				0
42.00	Radiology - Therapeutic			0
43.00	Radioisotope			0
44.00	Laboratory			0
44.01	Pathological Lab			0
46.00	Whole Blood			0
47.00	Blood Storing and Processing			0
48.00	Intravenous Therapy			0
49.00	Respiratory Therapy	392		392
50.00	Physical Therapy			0
51.00	Occupational Therapy			0
52.00	Speech Pathology			0
53.00	Electrocardiology			0
54.00	Electroencephalography			0
55.00	Medical Supplies Charged to Patients	100		100
56.00	Drugs Charged to Patients	114		114
57.00	Renal Dialysis			0
58.00	ASC (Non-Distinct Part)			0
59.00				0
59.01				0
59.02				0
59.03				0
60.00	Clinic			0
60.01	Other Clinic Services			0
61.00	Emergency	861		861
62.00	Observation Beds			0
63.00	Med. Transport			0
63.50	Rural Health Clinic			0
TOTAL MEDI-CAL ANCILLARY CHARGES		$ 1,467	$ 0	$ 1,467

(To Schedule 5)

STATE OF CALIFORNIA

SCHEDULE 7
PROGRAM: NONCONTRACT

COMPUTATION OF PROFESSIONAL COMPONENT OF HOSPITAL BASED PHYSICIAN'S REMUNERATION

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

Provider No:
ZZT30388F

	PROFESSIONAL SERVICE COST CENTERS	HBP REMUNERATION (Adj)	TOTAL CHARGES TO ALL PATIENTS (Adj)	RATIO OF REMUNERATION TO CHARGES	MEDI-CAL CHARGES (Adj)	MEDI-CAL COST
40.00	Anesthesiology	$ 0	$ 0	0.000000	$	$ 0
41.00	Radiology - Diagnostic	15,700	1,344,172	0.011680		0
43.00	Radioisotope	0	0	0.000000		0
44.00	Laboratory	14,000	885,130	0.015817		0
53.00	Electrocardiology	0	0	0.000000		0
54.00	Electroencephalography	0	0	0.000000		0
61.00	Emergency	504,478	806,599	0.625438	861	539
	TOTAL	$ 534,178	$ 3,035,901		$ 861	$ 539

(To Schedule 3)

COMPUTATION OF DISTINCT PART NURSING FACILITY PER DIEM

Provider Name: SOUTHERN INYO HOSPITAL

Fiscal Period Ended: JUNE 30, 2008

Provider No: LTC55527F

	REPORTED	AUDITED	DIFFERENCE
COMPUTATION OF DISTINCT PART (DP) NURSING FACILITY PER DIEM			
1. Distinct Part Ancillary Cost (DPNF Sch 3)	$ 0	$ 0	$ 0
2. Distinct Part Routine Cost (DPNF Sch 2)	$ 2,523,738	$ 2,442,381	$ (81,357)
3. Total Distinct Part Facility Cost (Lines 1 & 2)	$ 2,523,738	$ 2,442,381	$ (81,357)
4. Total Distinct Part Patient Days (Adj)	12,078	12,078	0
5. Average DP Per Diem Cost (Line 3 / Line 4)	$ 208.95	$ 202.22	$ (6.73)
DPNF OVERPAYMENT AND OVERBILLINGS			
6. Medi-Cal Overpayments (Adjs 18, 19)	$ 0	$ (2,992)	$ (2,992)
7. Medi-Cal Credit Balances (Adj 17)	$ 0	$ (3,566)	$ (3,566)
8. MEDI-CAL SETTLEMENT Due Provider (State)	$ 0	$ (6,558)	$ (6,558)
	(To Summary of Findings)		
GENERAL INFORMATION			
9. Total Available Distinct Part Beds (C/R, W/S S-3)	33	33	0
10. Total Licensed Capacity (All levels) (Adj)	37	37	0
11. Total Medi-Cal DP Patient Days (Adj 16)	7,432	11,053	3,621
CAPITAL RELATED COST			
12. Direct Capital Related Cost	N/A	$ 0	N/A
13. Indirect Capital Related Cost (DPNF Sch 5)	N/A	$ 57,753	N/A
14. Total Capital Related Cost (Lines 12 & 13)	N/A	$ 57,753	N/A
TOTAL SALARY & BENEFITS			
15. Direct Salary & Benefits Expenses	N/A	$ 908,599	N/A
16. Allocated Salary & Benefits (DPNF Sch 5)	N/A	$ 1,043,418	N/A
17. Total Salary & Benefits Expenses (Lines 15 & 16)	N/A	$ 1,952,017	N/A

SUMMARY OF DISTINCT PART FACILITY EXPENSES

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

Provider No:
LTC55527F

COL.	COST CENTER DIRECT AND ALLOCATED EXPENSE	REPORTED *	AUDITED *	DIFFERENCE
0.00	Distinct Part	$ 975,067	$ 964,906	$ (10,161)
1.00	Old Cap Rel Costs-Bldg & Fixtures		0	0
2.00	Old Cap Rel Costs-Movable Equipment		0	0
3.00	New Cap Rel Costs-Bldg & Fixtures		3,928	3,928
4.00	New Cap Rel Costs-Movable Equipment	26,799	20,911	(5,888)
4.01			0	0
4.02			0	0
4.03			0	0
4.04			0	0
4.05			0	0
4.06			0	0
4.07			0	0
4.08			0	0
5.00	Employee Benefits	249,422	249,405	(17)
6.01	Non-Patient Telephones		0	0
6.02	Data Processing		0	0
6.03	Purchasing/Receiving		0	0
6.04	Patient Admitting		0	0
6.05	Patient Business Office		0	0
6.06			0	0
6.07			0	0
6.08			0	0
6.00	Administrative and General	199,643	173,172	(26,471)
7.00	Maintenance and Repairs	105,332	96,132	(9,200)
8.00	Operation of Plant	74,121	72,101	(2,020)
9.00	Laundry and Linen Service	75,779	73,194	(2,585)
10.00	Housekeeping	65,878	61,326	(4,552)
11.00	Dietary	490,969	474,121	(16,848)
12.00	Cafeteria	28,518	25,881	(2,637)
13.00	Maintenance of Personnel		0	0
14.00	Nursing Administration	146,569	143,434	(3,135)
15.00	Central Services & Supply		0	0
16.00	Pharmacy		0	0
17.00	Medical Records and Library	85,641	83,870	(1,771)
18.00	Social Service		0	0
19.00			0	0
19.02			0	0
19.03			0	0
20.00			0	0
21.00	Nursing School		0	0
22.00	Intern & Res Service-Salary & Fringes		0	0
23.00	Intern & Res Other Program		0	0
24.00	Paramedical Ed Program		0	0
101.00	TOTAL DIRECT AND ALLOCATED EXPENSES	$ 2,523,738	$ 2,442,381	$ (81,357)

(To DPNF Sch 1)

* From Schedule 8, Part I, line 34.

SCHEDULE OF TOTAL DISTINCT PART ANCILLARY COSTS

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

Provider No:
LTC55527F

		TOTAL ANCILLARY COST *	TOTAL ANCILLARY CHARGES	RATIO COST TO CHARGES	TOTAL DP ANCILLARY CHARGES **	TOTAL ANCILLARY COST***
ANCILLARY COST CENTERS					**(From DPNF Sch 4)**	
49.00	Respiratory Therapy	$ 7,654	$ 183,337	0.041750	$ 0	$ 0
55.00	Med Supply Charged to Patients	192,205	432,006	0.444912	0	0
56.00	Drugs Charged to Patients	69,449	313,012	0.221872	0	0
101.00	TOTAL	$ 269,307	$ 928,355		$ 0	$ 0

(To DPNF Sch 1)

* From Schedule 8, Column 27.
** Total Distinct Part Ancillary Charges included in the rate.
*** Total Distinct Part Ancillary Costs included in the rate.

STATE OF CALIFORNIA DPNF SCH 4

ADJUSTMENTS TO TOTAL
DISTINCT PART ANCILLARY CHARGES

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

Provider No:
LTC55527F

ANCILLARY CHARGES		REPORTED	ADJUSTMENTS (Adj)	AUDITED
49.00	Respiratory Therapy	$	$	$ 0
55.00	Med Supply Charged to Patients			0
56.00	Drugs Charged to Patients			0
				0
				0
				0
				0
				0
				0
				0
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				0
				0
				0
TOTAL DP ANCILLARY CHARGES		$ 0	$ 0	$ 0

(To DPNF Sch 3)

ALLOCATION OF INDIRECT EXPENSES
DISTINCT PART NURSING FACILITY

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

Provider No:
LTC55527F

COL.	COST CENTER	AUDITED CAP RELATED * (COL 1)	AUDITED SAL & EMP BENEFITS * (COL 2)
1.00	Old Cap Rel Costs-Bldg & Fixtures	$ 0	$ N/A
2.00	Old Cap Rel Costs-Movable Equipment	0	N/A
3.00	New Cap Rel Costs-Bldg & Fixtures	3,928	N/A
4.00	New Cap Rel Costs-Movable Equipment	20,911	N/A
4.01		0	N/A
4.02		0	N/A
4.03		0	N/A
4.04		0	N/A
4.05		0	N/A
4.06		0	N/A
4.07		0	N/A
4.08		0	N/A
5.00	Employee Benefits	232	249,173
6.01	Non-Patient Telephones	0	0
6.02	Data Processing	0	0
6.03	Purchasing/Receiving	0	0
6.04	Patient Admitting	0	0
6.05	Patient Business Office	0	0
6.06		0	0
6.07		0	0
6.08		0	0
6.00	Administrative and General	1,826	122,845
7.00	Maintenance and Repairs	11,499	55,453
8.00	Operation of Plant	2,931	9,961
9.00	Laundry and Linen Service	4,953	51,027
10.00	Housekeeping	558	50,737
11.00	Dietary	6,596	326,313
12.00	Cafeteria	1,588	15,820
13.00	Maintenance of Personnel	0	0
14.00	Nursing Administration	1,906	87,749
15.00	Central Services & Supply	0	0
16.00	Pharmacy	0	0
17.00	Medical Records and Library	824	74,341
18.00	Social Service	0	0
19.00		0	0
19.02		0	0
19.03		0	0
20.00		0	0
21.00	Nursing School	0	0
22.00	Intern & Res Service-Salary & Fringes	0	0
23.00	Intern & Res Other Program	0	0
24.00	Paramedical Ed Program	0	0
101	TOTAL ALLOCATED INDIRECT EXPENSES	$ 57,753	$ 1,043,418

* These amounts include Skilled Nursing Facility expenses, line 34.

(To DPNF SCH 1)

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

	TRIAL BALANCE EXPENSES	NET EXP FOR COST ALLOC (From Sch 10) 0.00	OLD CAPITAL BLDG & FIXTURES 1.00	OLD MOVABLE EQUIP 2.00	NEW CAPITAL BLDG & FIXTURES 3.00	NEW MOVABLE EQUIP 4.00	ALLOC COST 4.01	ALLOC COST 4.02	ALLOC COST 4.03	ALLOC COST 4.04	ALLOC COST 4.05	ALLOC COST 4.06	ALLOC COST 4.07
	GENERAL SERVICE COST CENTER												
1.00	Old Cap Rel Costs-Bldg & Fixtures	0											
2.00	Old Cap Rel Costs-Movable Equipmer	0	0										
3.00	New Cap Rel Costs-Bldg & Fixtures	18,848	0	0									
4.00	New Cap Rel Costs-Movable Equipme	128,328	0	0	0								
4.01		0	0	0	0	0							
4.02		0	0	0	0	0	0						
4.03		0	0	0	0	0	0	0					
4.04		0	0	0	0	0	0	0	0				
4.05		0	0	0	0	0	0	0	0	0			
4.06		0	0	0	0	0	0	0	0	0	0		
4.07		0	0	0	0	0	0	0	0	0	0	0	
4.08		0	0	0	0	0	0	0	0	0	0	0	0
5.00	Employee Benefits	901,075	0	0	133	707	0	0	0	0	0	0	0
6.01	Non-Patient Telephones	0	0	0	0	0	0	0	0	0	0	0	0
6.02	Data Processing	0	0	0	0	0	0	0	0	0	0	0	0
6.03	Purchasing/Receiving	0	0	0	0	0	0	0	0	0	0	0	0
6.04	Patient Admitting	0	0	0	0	0	0	0	0	0	0	0	0
6.05	Patient Business Office	0	0	0	0	0	0	0	0	0	0	0	0
6.06		0	0	0	0	0	0	0	0	0	0	0	0
6.07		0	0	0	0	0	0	0	0	0	0	0	0
6.08		0	0	0	0	0	0	0	0	0	0	0	0
6.00	Administrative and General	642,613	0	0	1,263	6,726	0	0	0	0	0	0	0
7.00	Maintenance and Repairs	241,411	0	0	6,905	36,762	0	0	0	0	0	0	0
8.00	Operation of Plant	194,908	0	0	1,096	5,837	0	0	0	0	0	0	0
9.00	Laundry and Linen Service	40,385	0	0	570	3,037	0	0	0	0	0	0	0
10.00	Housekeeping	149,649	0	0	168	895	0	0	0	0	0	0	0
11.00	Dietary	354,265	0	0	645	3,432	0	0	0	0	0	0	0
12.00	Cafeteria	0	0	0	260	1,382	0	0	0	0	0	0	0
13.00	Maintenance of Personnel	0	0	0	0	0	0	0	0	0	0	0	0
14.00	Nursing Administration	131,088	0	0	217	1,155	0	0	0	0	0	0	0
15.00	Central Services & Supply	35,125	0	0	443	2,356	0	0	0	0	0	0	0
16.00	Pharmacy	12,762	0	0	69	369	0	0	0	0	0	0	0
17.00	Medical Records and Library	145,608	0	0	169	898	0	0	0	0	0	0	0
18.00	Social Service	0	0	0	0	0	0	0	0	0	0	0	0
19.00		0	0	0	0	0	0	0	0	0	0	0	0
19.02		0	0	0	0	0	0	0	0	0	0	0	0
19.03		0	0	0	0	0	0	0	0	0	0	0	0
20.00		0	0	0	0	0	0	0	0	0	0	0	0
21.00	Nursing School	0	0	0	0	0	0	0	0	0	0	0	0
22.00	Intern & Res Service-Salary & Fringes	0	0	0	0	0	0	0	0	0	0	0	0
23.00	Intern & Res Other Program	0	0	0	0	0	0	0	0	0	0	0	0
24.00	Paramedical Ed Program	0	0	0	0	0	0	0	0	0	0	0	0
	INPATIENT ROUTINE COST CENTERS												
25.00	Adults & Pediatrics (Gen Routine)	138,493	0	0	349	1,859	0	0	0	0	0	0	0
26.00	Intensive Care Unit	0	0	0	0	0	0	0	0	0	0	0	0
27.00	Coronary Care Unit	0	0	0	0	0	0	0	0	0	0	0	0
28.00	Neonatal Intensive Care Unit	0	0	0	0	0	0	0	0	0	0	0	0
29.00	Surgical Intensive Care	0	0	0	0	0	0	0	0	0	0	0	0
30.00	Subprovider I	0	0	0	0	0	0	0	0	0	0	0	0
31.00	Subprovider II	0	0	0	0	0	0	0	0	0	0	0	0
32.00		0	0	0	0	0	0	0	0	0	0	0	0
33.00	Nursery	0	0	0	0	0	0	0	0	0	0	0	0
34.00	Skilled Nursing Facility	964,906	0	0	3,928	20,911	0	0	0	0	0	0	0
35.00	Distinct Part Nursing Facility	0	0	0	0	0	0	0	0	0	0	0	0
36.00	Adult Subacute Care Unit	0	0	0	0	0	0	0	0	0	0	0	0
36.01	Subacute Care Unit II	0	0	0	0	0	0	0	0	0	0	0	0
36.02	Transitional Care Unit	0	0	0	0	0	0	0	0	0	0	0	0

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

	TRIAL BALANCE EXPENSES	NET EXP FOR COST ALLOC (From Sch 10) 0.00	OLD CAPITAL BLDG & FIXTURES 1.00	OLD MOVABLE EQUIP 2.00	NEW CAPITAL BLDG & FIXTURES 3.00	NEW MOVABLE EQUIP 4.00	ALLOC COST 4.01	ALLOC COST 4.02	ALLOC COST 4.03	ALLOC COST 4.04	ALLOC COST 4.05	ALLOC COST 4.06	ALLOC COST 4.07
	ANCILLARY COST CENTERS												
37.00	Operating Room	0	0	0	0	0	0	0	0	0	0	0	0
38.00	Recovery Room	0	0	0	0	0	0	0	0	0	0	0	0
39.00	Delivery Room and Labor Room	0	0	0	0	0	0	0	0	0	0	0	0
40.00	Anesthesiology	0	0	0	0	0	0	0	0	0	0	0	0
41.00	Radiology - Diagnostic	450,461	0	0	598	3,185	0	0	0	0	0	0	0
41.01		0	0	0	0	0	0	0	0	0	0	0	0
41.02		0	0	0	0	0	0	0	0	0	0	0	0
42.00	Radiology - Therapeutic	0	0	0	0	0	0	0	0	0	0	0	0
43.00	Radioisotope	0	0	0	0	0	0	0	0	0	0	0	0
44.00	Laboratory	479,338	0	0	547	2,912	0	0	0	0	0	0	0
44.01	Pathological Lab	0	0	0	0	0	0	0	0	0	0	0	0
46.00	Whole Blood	9,163	0	0	0	0	0	0	0	0	0	0	0
47.00	Blood Storing and Processing	0	0	0	0	0	0	0	0	0	0	0	0
48.00	Intravenous Therapy	0	0	0	0	0	0	0	0	0	0	0	0
49.00	Respiratory Therapy	1,279	0	0	19	99	0	0	0	0	0	0	0
50.00	Physical Therapy	197,177	0	0	1,086	5,785	0	0	0	0	0	0	0
51.00	Occupational Therapy	0	0	0	0	0	0	0	0	0	0	0	0
52.00	Speech Pathology	0	0	0	0	0	0	0	0	0	0	0	0
53.00	Electrocardiology	0	0	0	0	0	0	0	0	0	0	0	0
54.00	Electroencephalography	0	0	0	0	0	0	0	0	0	0	0	0
55.00	Medical Supplies Charged to Patients	89,755	0	0	0	0	0	0	0	0	0	0	0
56.00	Drugs Charged to Patients	34,723	0	0	0	0	0	0	0	0	0	0	0
57.00	Renal Dialysis	0	0	0	0	0	0	0	0	0	0	0	0
58.00	ASC (Non-Distinct Part)	0	0	0	0	0	0	0	0	0	0	0	0
59.00		0	0	0	0	0	0	0	0	0	0	0	0
59.01		0	0	0	0	0	0	0	0	0	0	0	0
59.02		0	0	0	0	0	0	0	0	0	0	0	0
59.03		0	0	0	0	0	0	0	0	0	0	0	0
60.00	Clinic	0	0	0	0	0	0	0	0	0	0	0	0
60.01	Other Clinic Services	0	0	0	0	0	0	0	0	0	0	0	0
61.00	Emergency	252,718	0	0	384	5,834	0	0	0	0	0	0	0
62.00	Observation Beds	0	0	0	0	0	0	0	0	0	0	0	0
63.00	Med. Transport	14,118	0	0	0	0	0	0	0	0	0	0	0
63.50	Rural Health Clinic	634,946	0	0	0	24,186	0	0	0	0	0	0	0
83.00		0	0	0	0	0	0	0	0	0	0	0	0
84.00		0	0	0	0	0	0	0	0	0	0	0	0
85.00		0	0	0	0	0	0	0	0	0	0	0	0
86.00		0	0	0	0	0	0	0	0	0	0	0	0
	NONREIMBURSABLE COST CENTERS												
96.00	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0	0	0	0	0
97.00	Research	0	0	0	0	0	0	0	0	0	0	0	0
98.00	Physicians' Private Office	0	0	0	0	0	0	0	0	0	0	0	0
99.00	Nonpaid Workers	0	0	0	0	0	0	0	0	0	0	0	0
99.01		0	0	0	0	0	0	0	0	0	0	0	0
99.02		0	0	0	0	0	0	0	0	0	0	0	0
99.03		0	0	0	0	0	0	0	0	0	0	0	0
99.04		0	0	0	0	0	0	0	0	0	0	0	0
99.05		0	0	0	0	0	0	0	0	0	0	0	0
100.00	Nonreimbursable Meals	0	0	0	0	0	0	0	0	0	0	0	0
100.01		0	0	0	0	0	0	0	0	0	0	0	0
100.02		0	0	0	0	0	0	0	0	0	0	0	0
100.03		0	0	0	0	0	0	0	0	0	0	0	0
100.04		0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL	6,263,142	0	0	18,848	128,328	0	0	0	0	0	0	0

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

	TRIAL BALANCE EXPENSES	ALLOC COST 4.08	EMPLOYEE BENEFITS 5.00	ALLOC COST 6.01	ALLOC COST 6.02	ALLOC COST 6.03	ALLOC COST 6.04	ALLOC COST 6.05	ALLOC COST 6.06	ALLOC COST 6.07	ALLOC COST 6.08	ACCUMULATE COST	ADMINIS-TRATIVE & GENERAL 6.00
	GENERAL SERVICE COST CENTER												
1.00	Old Cap Rel Costs-Bldg & Fixtures												
2.00	Old Cap Rel Costs-Movable Equipmer												
3.00	New Cap Rel Costs-Bldg & Fixtures												
4.00	New Cap Rel Costs-Movable Equipme												
4.01													
4.02													
4.03													
4.04													
4.05													
4.06													
4.07													
4.08													
5.00	Employee Benefits	0											
6.01	Non-Patient Telephones	0	0										
6.02	Data Processing	0	0	0									
6.03	Purchasing/Receiving	0	0	0	0								
6.04	Patient Admitting	0	0	0	0	0							
6.05	Patient Business Office	0	0	0	0	0	0						
6.06		0	0	0	0	0	0	0					
6.07		0	0	0	0	0	0	0	0				
6.08		0	0	0	0	0	0	0	0	0			
6.00	Administrative and General	0	117,354	0	0	0	0	0	0	0	0	767,956	
7.00	Maintenance and Repairs	0	38,975	0	0	0	0	0	0	0	0	324,052	45,287
8.00	Operation of Plant	0	0	0	0	0	0	0	0	0	0	201,842	28,208
9.00	Laundry and Linen Service	0	9,661	0	0	0	0	0	0	0	0	53,653	7,498
10.00	Housekeeping	0	34,312	0	0	0	0	0	0	0	0	185,024	25,857
11.00	Dietary	0	63,798	0	0	0	0	0	0	0	0	422,139	58,994
12.00	Cafeteria	0	0	0	0	0	0	0	0	0	0	1,642	229
13.00	Maintenance of Personnel	0	0	0	0	0	0	0	0	0	0	0	0
14.00	Nursing Administration	0	19,923	0	0	0	0	0	0	0	0	152,383	21,296
15.00	Central Services & Supply	0	8,023	0	0	0	0	0	0	0	0	45,946	6,421
16.00	Pharmacy	0	2,624	0	0	0	0	0	0	0	0	15,824	2,211
17.00	Medical Records and Library	0	37,022	0	0	0	0	0	0	0	0	183,697	25,672
18.00	Social Service	0	0	0	0	0	0	0	0	0	0	0	0
19.00		0	0	0	0	0	0	0	0	0	0	0	0
19.02		0	0	0	0	0	0	0	0	0	0	0	0
19.03		0	0	0	0	0	0	0	0	0	0	0	0
20.00		0	0	0	0	0	0	0	0	0	0	0	0
21.00	Nursing School	0	0	0	0	0	0	0	0	0	0	0	0
22.00	Intern & Res Service-Salary & Fringes	0	0	0	0	0	0	0	0	0	0	0	0
23.00	Intern & Res Other Program	0	0	0	0	0	0	0	0	0	0	0	0
24.00	Paramedical Ed Program	0	0	0	0	0	0	0	0	0	0	0	0
	INPATIENT ROUTINE COST CENTE												
25.00	Adults & Pediatrics (Gen Routine)	0	7,508	0	0	0	0	0	0	0	0	148,209	20,712
26.00	Intensive Care Unit	0	0	0	0	0	0	0	0	0	0	0	0
27.00	Coronary Care Unit	0	0	0	0	0	0	0	0	0	0	0	0
28.00	Neonatal Intensive Care Unit	0	0	0	0	0	0	0	0	0	0	0	0
29.00	Surgical Intensive Care	0	0	0	0	0	0	0	0	0	0	0	0
30.00	Subprovider I	0	0	0	0	0	0	0	0	0	0	0	0
31.00	Subprovider II	0	0	0	0	0	0	0	0	0	0	0	0
32.00		0	0	0	0	0	0	0	0	0	0	0	0
33.00	Nursery	0	0	0	0	0	0	0	0	0	0	0	0
34.00	Skilled Nursing Facility	0	249,405	0	0	0	0	0	0	0	0	1,239,150	173,172
35.00	Distinct Part Nursing Facility	0	0	0	0	0	0	0	0	0	0	0	0
36.00	Adult Subacute Care Unit	0	0	0	0	0	0	0	0	0	0	0	0
36.01	Subacute Care Unit II	0	0	0	0	0	0	0	0	0	0	0	0
36.02	Transitional Care Unit	0	0	0	0	0	0	0	0	0	0	0	0

STATE OF CALIFORNIA | COMPUTATION OF COST ALLOCATION (W/S B) | SCHEDULE 8.1

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

	TRIAL BALANCE EXPENSES	ALLOC COST 4.08	EMPLOYEE BENEFITS 5.00	ALLOC COST 6.01	ALLOC COST 6.02	ALLOC COST 6.03	ALLOC COST 6.04	ALLOC COST 6.05	ALLOC COST 6.06	ALLOC COST 6.07	ALLOC COST 6.08	ACCUMULATE COST	ADMINIS-TRATIVE & GENERAL 6.00
	ANCILLARY COST CENTERS												
37.00	Operating Room	0	0	0	0	0	0	0	0	0	0	0	0
38.00	Recovery Room	0	0	0	0	0	0	0	0	0	0	0	0
39.00	Delivery Room and Labor Room	0	0	0	0	0	0	0	0	0	0	0	0
40.00	Anesthesiology	0	0	0	0	0	0	0	0	0	0	0	0
41.00	Radiology - Diagnostic	0	59,791	0	0	0	0	0	0	0	0	514,036	71,837
41.01		0	0	0	0	0	0	0	0	0	0	0	0
41.02		0	0	0	0	0	0	0	0	0	0	0	0
42.00	Radiology - Therapeutic	0	0	0	0	0	0	0	0	0	0	0	0
43.00	Radioisotope	0	0	0	0	0	0	0	0	0	0	0	0
44.00	Laboratory	0	71,975	0	0	0	0	0	0	0	0	554,772	77,530
44.01	Pathological Lab	0	0	0	0	0	0	0	0	0	0	0	0
46.00	Whole Blood	0	0	0	0	0	0	0	0	0	0	9,163	1,281
47.00	Blood Storing and Processing	0	0	0	0	0	0	0	0	0	0	0	0
48.00	Intravenous Therapy	0	0	0	0	0	0	0	0	0	0	0	0
49.00	Respiratory Therapy	0	351	0	0	0	0	0	0	0	0	1,747	244
50.00	Physical Therapy	0	49,243	0	0	0	0	0	0	0	0	253,291	35,398
51.00	Occupational Therapy	0	0	0	0	0	0	0	0	0	0	0	0
52.00	Speech Pathology	0	0	0	0	0	0	0	0	0	0	0	0
53.00	Electrocardiology	0	0	0	0	0	0	0	0	0	0	0	0
54.00	Electroencephalography	0	0	0	0	0	0	0	0	0	0	0	0
55.00	Medical Supplies Charged to Patients	0	0	0	0	0	0	0	0	0	0	89,755	12,543
56.00	Drugs Charged to Patients	0	0	0	0	0	0	0	0	0	0	34,723	4,853
57.00	Renal Dialysis	0	0	0	0	0	0	0	0	0	0	0	0
58.00	ASC (Non-Distinct Part)	0	0	0	0	0	0	0	0	0	0	0	0
59.00		0	0	0	0	0	0	0	0	0	0	0	0
59.01		0	0	0	0	0	0	0	0	0	0	0	0
59.02		0	0	0	0	0	0	0	0	0	0	0	0
59.03		0	0	0	0	0	0	0	0	0	0	0	0
60.00	Clinic	0	0	0	0	0	0	0	0	0	0	0	0
60.01	Other Clinic Services	0	0	0	0	0	0	0	0	0	0	0	0
61.00	Emergency	0	32,720	0	0	0	0	0	0	0	0	291,656	40,759
62.00	Observation Beds	0	0	0	0	0	0	0	0	0	0	0	0
63.00	Med. Transport	0	1,081	0	0	0	0	0	0	0	0	15,199	2,124
63.50	Rural Health Clinic	0	98,150	0	0	0	0	0	0	0	0	757,281	105,831
83.00		0	0	0	0	0	0	0	0	0	0	0	0
84.00		0	0	0	0	0	0	0	0	0	0	0	0
85.00		0	0	0	0	0	0	0	0	0	0	0	0
86.00		0	0	0	0	0	0	0	0	0	0	0	0
	NONREIMBURSABLE COST CENTE												
96.00	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0	0	0	0	0
97.00	Research	0	0	0	0	0	0	0	0	0	0	0	0
98.00	Physicians' Private Office	0	0	0	0	0	0	0	0	0	0	0	0
99.00	Nonpaid Workers	0	0	0	0	0	0	0	0	0	0	0	0
99.01		0	0	0	0	0	0	0	0	0	0	0	0
99.02		0	0	0	0	0	0	0	0	0	0	0	0
99.03		0	0	0	0	0	0	0	0	0	0	0	0
99.04		0	0	0	0	0	0	0	0	0	0	0	0
99.05		0	0	0	0	0	0	0	0	0	0	0	0
100.00	Nonreimbursable Meals	0	0	0	0	0	0	0	0	0	0	0	0
100.01		0	0	0	0	0	0	0	0	0	0	0	0
100.02		0	0	0	0	0	0	0	0	0	0	0	0
100.03		0	0	0	0	0	0	0	0	0	0	0	0
100.04		0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL	0	901,915	0	0	0	0	0	0	0	0	6,263,142	767,956

STATE OF CALIFORNIA

COMPUTATION OF COST ALLOCATION (W/S B)

SCHEDULE 8.2

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

	TRIAL BALANCE EXPENSES	MAINT & REPAIRS 7.00	OPER PLANT 8.00	LAUNDRY & LINEN 9.00	HOUSEKEEP 10.00	DIETARY 11.00	CAFE 12.00	MAINT OF PERSONNEL 13.00	NURSING ADMIN 14.00	CENTRAL SERVICE & SUPPLY 15.00	PHARMACY 16.00	MEDICAL RECORDS & LIBRARY 17.00	SOCIAL SERVICE 18.00
	GENERAL SERVICE COST CENTER												
1.00	Old Cap Rel Costs-Bldg & Fixtures												
2.00	Old Cap Rel Costs-Movable Equipmer												
3.00	New Cap Rel Costs-Bldg & Fixtures												
4.00	New Cap Rel Costs-Movable Equipme												
4.01													
4.02													
4.03													
4.04													
4.05													
4.06													
4.07													
4.08													
5.00	Employee Benefits												
6.01	Non-Patient Telephones												
6.02	Data Processing												
6.03	Purchasing/Receiving												
6.04	Patient Admitting												
6.05	Patient Business Office												
6.06													
6.07													
6.08													
6.00	Administrative and General												
7.00	Maintenance and Repairs												
8.00	Operation of Plant	26,835											
9.00	Laundry and Linen Service	13,962	10,472										
10.00	Housekeeping	4,115	3,086	0									
11.00	Dietary	15,777	11,833	0	10,065								
12.00	Cafeteria	6,353	4,765	0	4,053	33,506							
13.00	Maintenance of Personnel	0	0	0	0	0	0						
14.00	Nursing Administration	5,310	3,982	0	3,387	0	708	0					
15.00	Central Services & Supply	10,831	8,123	71	6,909	0	998	0	0				
16.00	Pharmacy	1,694	1,271	0	1,081	0	107	0	0	0			
17.00	Medical Records and Library	4,130	3,097	0	2,634	0	2,684	0	0	0	0		
18.00	Social Service	0	0	0	0	0	0	0	0	0	0	0	
19.00		0	0	0	0	0	0	0	0	0	0	0	0
19.02		0	0	0	0	0	0	0	0	0	0	0	0
19.03		0	0	0	0	0	0	0	0	0	0	0	0
20.00		0	0	0	0	0	0	0	0	0	0	0	0
21.00	Nursing School	0	0	0	0	0	0	0	0	0	0	0	0
22.00	Intern & Res Service-Salary & Fringes	0	0	0	0	0	0	0	0	0	0	0	0
23.00	Intern & Res Other Program	0	0	0	0	0	0	0	0	0	0	0	0
24.00	Paramedical Ed Program	0	0	0	0	0	0	0	0	0	0	0	0
	INPATIENT ROUTINE COST CENTE												
25.00	Adults & Pediatrics (Gen Routine)	8,547	6,410	67	5,452	8,057	601	0	4,325	0	0	1,264	0
26.00	Intensive Care Unit	0	0	0	0	0	0	0	0	0	0	0	0
27.00	Coronary Care Unit	0	0	0	0	0	0	0	0	0	0	0	0
28.00	Neonatal Intensive Care Unit	0	0	0	0	0	0	0	0	0	0	0	0
29.00	Surgical Intensive Care	0	0	0	0	0	0	0	0	0	0	0	0
30.00	Subprovider I	0	0	0	0	0	0	0	0	0	0	0	0
31.00	Subprovider II	0	0	0	0	0	0	0	0	0	0	0	0
32.00		0	0	0	0	0	0	0	0	0	0	0	0
33.00	Nursery	0	0	0	0	0	0	0	0	0	0	0	0
34.00	Skilled Nursing Facility	96,132	72,101	73,194	61,326	474,121	25,881	0	143,434	0	0	83,870	0
35.00	Distinct Part Nursing Facility	0	0	0	0	0	0	0	0	0	0	0	0
36.00	Adult Subacute Care Unit	0	0	0	0	0	0	0	0	0	0	0	0
36.01	Subacute Care Unit II	0	0	0	0	0	0	0	0	0	0	0	0
36.02	Transitional Care Unit	0	0	0	0	0	0	0	0	0	0	0	0

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

	TRIAL BALANCE EXPENSES	MAINT & REPAIRS 7.00	OPER PLANT 8.00	LAUNDRY & LINEN 9.00	HOUSEKEEP 10.00	DIETARY 11.00	CAFE 12.00	MAINT OF PERSONNEL 13.00	NURSING ADMIN 14.00	CENTRAL SERVICE & SUPPLY 15.00	PHARMACY 16.00	MEDICAL RECORDS & LIBRARY 17.00	SOCIAL SERVICE 18.00
	ANCILLARY COST CENTERS												
37.00	Operating Room	0	0	0	0	0	0	0	0	0	0	0	0
38.00	Recovery Room	0	0	0	0	0	0	0	0	0	0	0	0
39.00	Delivery Room and Labor Room	0	0	0	0	0	0	0	0	0	0	0	0
40.00	Anesthesiology	0	0	0	0	0	0	0	0	0	0	0	0
41.00	Radiology - Diagnostic	14,643	10,982	642	9,341	0	5,689	0	0	0	0	33,000	0
41.01		0	0	0	0	0	0	0	0	0	0	0	0
41.02		0	0	0	0	0	0	0	0	0	0	0	0
42.00	Radiology - Therapeutic	0	0	0	0	0	0	0	0	0	0	0	0
43.00	Radioisotope	0	0	0	0	0	0	0	0	0	0	0	0
44.00	Laboratory	13,387	10,041	0	8,540	0	2,791	0	0	0	0	21,730	0
44.01	Pathological Lab	0	0	0	0	0	0	0	0	0	0	0	0
46.00	Whole Blood	0	0	0	0	0	0	0	0	0	0	76	0
47.00	Blood Storing and Processing	0	0	0	0	0	0	0	0	0	0	0	0
48.00	Intravenous Therapy	0	0	0	0	0	0	0	0	0	0	0	0
49.00	Respiratory Therapy	454	340	0	290	0	21	0	57	0	0	4,501	0
50.00	Physical Therapy	26,593	19,945	9,460	16,965	0	3,864	0	1,413	0	0	20,915	0
51.00	Occupational Therapy	0	0	0	0	0	0	0	0	0	0	0	0
52.00	Speech Pathology	0	0	0	0	0	0	0	0	0	0	0	0
53.00	Electrocardiology	0	0	0	0	0	0	0	0	0	0	0	0
54.00	Electroencephalography	0	0	0	0	0	0	0	0	0	0	0	0
55.00	Medical Supplies Charged to Patients	0	0	0	0	0	0	0	0	79,300	0	10,606	0
56.00	Drugs Charged to Patients	0	0	0	0	0	0	0	0	0	22,188	7,685	0
57.00	Renal Dialysis	0	0	0	0	0	0	0	0	0	0	0	0
58.00	ASC (Non-Distinct Part)	0	0	0	0	0	0	0	0	0	0	0	0
59.00		0	0	0	0	0	0	0	0	0	0	0	0
59.01		0	0	0	0	0	0	0	0	0	0	0	0
59.02		0	0	0	0	0	0	0	0	0	0	0	0
59.03		0	0	0	0	0	0	0	0	0	0	0	0
60.00	Clinic	0	0	0	0	0	0	0	0	0	0	0	0
60.01	Other Clinic Services	0	0	0	0	0	0	0	0	0	0	0	0
61.00	Emergency	9,394	7,046	1,415	17,110	0	2,619	0	24,001	0	0	19,802	0
62.00	Observation Beds	0	0	0	0	0	0	0	0	0	0	0	0
63.00	Med. Transport	0	0	0	0	0	118	0	0	0	0	267	0
63.50	Rural Health Clinic	111,183	83,389	736	70,928	0	4,466	0	13,838	0	0	18,197	0
83.00		0	0	0	0	0	0	0	0	0	0	0	0
84.00		0	0	0	0	0	0	0	0	0	0	0	0
85.00		0	0	0	0	0	0	0	0	0	0	0	0
86.00		0	0	0	0	0	0	0	0	0	0	0	0
	NONREIMBURSABLE COST CENTE												
96.00	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0	0	0	0	0
97.00	Research	0	0	0	0	0	0	0	0	0	0	0	0
98.00	Physicians' Private Office	0	0	0	0	0	0	0	0	0	0	0	0
99.00	Nonpaid Workers	0	0	0	0	0	0	0	0	0	0	0	0
99.01		0	0	0	0	0	0	0	0	0	0	0	0
99.02		0	0	0	0	0	0	0	0	0	0	0	0
99.03		0	0	0	0	0	0	0	0	0	0	0	0
99.04		0	0	0	0	0	0	0	0	0	0	0	0
99.05		0	0	0	0	0	0	0	0	0	0	0	0
100.00	Nonreimbursable Meals	0	0	0	0	3,125	0	0	0	0	0	0	0
100.01		0	0	0	0	0	0	0	0	0	0	0	0
100.02		0	0	0	0	0	0	0	0	0	0	0	0
100.03		0	0	0	0	0	0	0	0	0	0	0	0
100.04		0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL	369,339	256,884	85,585	218,082	518,809	50,548	0	187,066	79,300	22,188	221,913	0

STATE OF CALIFORNIA | COMPUTATION OF COST ALLOCATION (W/S B) | SCHEDULE 8.3

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

	TRIAL BALANCE EXPENSES	ALLOC COST 19.00	ALLOC COST 19.02	ALLOC COST 19.03	NON-PHYSICIAN ANESTH 20.00	NURSING SCHOOL 21.00	INT & RES SALARY & FRINGES 22.00	INT & RES PROGRAM 23.00	PARAMED EDUCAT 24.00	SUBTOTAL 25.00	POST STEP-DOWN ADJUSTMENT 26.00	TOTAL COST 27.00
	GENERAL SERVICE COST CENTER											
1.00	Old Cap Rel Costs-Bldg & Fixtures											
2.00	Old Cap Rel Costs-Movable Equipmer											
3.00	New Cap Rel Costs-Bldg & Fixtures											
4.00	New Cap Rel Costs-Movable Equipme											
4.01												
4.02												
4.03												
4.04												
4.05												
4.06												
4.07												
4.08												
5.00	Employee Benefits											
6.01	Non-Patient Telephones											
6.02	Data Processing											
6.03	Purchasing/Receiving											
6.04	Patient Admitting											
6.05	Patient Business Office											
6.06												
6.07												
6.08												
6.00	Administrative and General											
7.00	Maintenance and Repairs											
8.00	Operation of Plant											
9.00	Laundry and Linen Service											
10.00	Housekeeping											
11.00	Dietary											
12.00	Cafeteria											
13.00	Maintenance of Personnel											
14.00	Nursing Administration											
15.00	Central Services & Supply											
16.00	Pharmacy											
17.00	Medical Records and Library											
18.00	Social Service											
19.00												
19.02		0										
19.03		0	0									
20.00		0	0	0								
21.00	Nursing School	0	0	0	0							
22.00	Intern & Res Service-Salary & Fringes	0	0	0	0	0						
23.00	Intern & Res Other Program	0	0	0	0	0	0					
24.00	Paramedical Ed Program	0	0	0	0	0	0	0				
	INPATIENT ROUTINE COST CENTE											
25.00	Adults & Pediatrics (Gen Routine)	0	0	0	0	0	0	0	0	203,645		203,645
26.00	Intensive Care Unit	0	0	0	0	0	0	0	0	0		0
27.00	Coronary Care Unit	0	0	0	0	0	0	0	0	0		0
28.00	Neonatal Intensive Care Unit	0	0	0	0	0	0	0	0	0		0
29.00	Surgical Intensive Care	0	0	0	0	0	0	0	0	0		0
30.00	Subprovider I	0	0	0	0	0	0	0	0	0		0
31.00	Subprovider II	0	0	0	0	0	0	0	0	0		0
32.00		0	0	0	0	0	0	0	0	0		0
33.00	Nursery	0	0	0	0	0	0	0	0	0		0
34.00	Skilled Nursing Facility	0	0	0	0	0	0	0	0	2,442,381		2,442,381
35.00	Distinct Part Nursing Facility	0	0	0	0	0	0	0	0	0		0
36.00	Adult Subacute Care Unit	0	0	0	0	0	0	0	0	0		0
36.01	Subacute Care Unit II	0	0	0	0	0	0	0	0	0		0
36.02	Transitional Care Unit	0	0	0	0	0	0	0	0	0		0

STATE OF CALIFORNIA — COMPUTATION OF COST ALLOCATION (W/S B) — SCHEDULE 8.3

Provider Name: SOUTHERN INYO HOSPITAL

Fiscal Period Ended: JUNE 30, 2008

	TRIAL BALANCE EXPENSES	ALLOC COST 19.00	ALLOC COST 19.02	ALLOC COST 19.03	NON-PHYSICIAN ANESTH 20.00	NURSING SCHOOL 21.00	INT & RES SALARY & FRINGES 22.00	INT & RES PROGRAM 23.00	PARAMED EDUCAT 24.00	SUBTOTAL 25.00	POST STEP-DOWN ADJUSTMENT 26.00	TOTAL COST 27.00
	ANCILLARY COST CENTERS											
37.00	Operating Room	0	0	0	0	0	0	0	0	0		0
38.00	Recovery Room	0	0	0	0	0	0	0	0	0		0
39.00	Delivery Room and Labor Room	0	0	0	0	0	0	0	0	0		0
40.00	Anesthesiology	0	0	0	0	0	0	0	0	0		0
41.00	Radiology - Diagnostic	0	0	0	0	0	0	0	0	660,171		660,171
41.01		0	0	0	0	0	0	0	0	0		0
41.02		0	0	0	0	0	0	0	0	0		0
42.00	Radiology - Therapeutic	0	0	0	0	0	0	0	0	0		0
43.00	Radioisotope	0	0	0	0	0	0	0	0	0		0
44.00	Laboratory	0	0	0	0	0	0	0	0	688,791		688,791
44.01	Pathological Lab	0	0	0	0	0	0	0	0	0		0
46.00	Whole Blood	0	0	0	0	0	0	0	0	10,519		10,519
47.00	Blood Storing and Processing	0	0	0	0	0	0	0	0	0		0
48.00	Intravenous Therapy	0	0	0	0	0	0	0	0	0		0
49.00	Respiratory Therapy	0	0	0	0	0	0	0	0	7,654		7,654
50.00	Physical Therapy	0	0	0	0	0	0	0	0	387,844		387,844
51.00	Occupational Therapy	0	0	0	0	0	0	0	0	0		0
52.00	Speech Pathology	0	0	0	0	0	0	0	0	0		0
53.00	Electrocardiology	0	0	0	0	0	0	0	0	0		0
54.00	Electroencephalography	0	0	0	0	0	0	0	0	0		0
55.00	Medical Supplies Charged to Patients	0	0	0	0	0	0	0	0	192,205		192,205
56.00	Drugs Charged to Patients	0	0	0	0	0	0	0	0	69,449		69,449
57.00	Renal Dialysis	0	0	0	0	0	0	0	0	0		0
58.00	ASC (Non-Distinct Part)	0	0	0	0	0	0	0	0	0		0
59.00		0	0	0	0	0	0	0	0	0		0
59.01		0	0	0	0	0	0	0	0	0		0
59.02		0	0	0	0	0	0	0	0	0		0
59.03		0	0	0	0	0	0	0	0	0		0
60.00	Clinic	0	0	0	0	0	0	0	0	0		0
60.01	Other Clinic Services	0	0	0	0	0	0	0	0	0		0
61.00	Emergency	0	0	0	0	0	0	0	0	413,801		413,801
62.00	Observation Beds	0	0	0	0	0	0	0	0	0		0
63.00	Med. Transport	0	0	0	0	0	0	0	0	17,708		17,708
63.50	Rural Health Clinic	0	0	0	0	0	0	0	0	1,165,849		1,165,849
83.00		0	0	0	0	0	0	0	0	0		0
84.00		0	0	0	0	0	0	0	0	0		0
85.00		0	0	0	0	0	0	0	0	0		0
86.00		0	0	0	0	0	0	0	0	0		0
	NONREIMBURSABLE COST CENTER:											
96.00	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0	0		0
97.00	Research	0	0	0	0	0	0	0	0	0		0
98.00	Physicians' Private Office	0	0	0	0	0	0	0	0	0		0
99.00	Nonpaid Workers	0	0	0	0	0	0	0	0	0		0
99.01		0	0	0	0	0	0	0	0	0		0
99.02		0	0	0	0	0	0	0	0	0		0
99.03		0	0	0	0	0	0	0	0	0		0
99.04		0	0	0	0	0	0	0	0	0		0
99.05		0	0	0	0	0	0	0	0	0		0
100.00	Nonreimbursable Meals	0	0	0	0	0	0	0	0	3,125		3,125
100.01		0	0	0	0	0	0	0	0	0		0
100.02		0	0	0	0	0	0	0	0	0		0
100.03		0	0	0	0	0	0	0	0	0		0
100.04		0	0	0	0	0	0	0	0	0		0
	TOTAL	0	0	0	0	0	0	0	0	6,263,142	0	6,263,142

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

		OLD BLDG & FIXTURES (SQ FT)	OLD MOVBLE EQUIP (SQ FT)	NEW BLDG & FIXTURES (SQ FT)	NEW MOVBLE EQUIP (SQ FT)	STAT	STAT	STAT	STAT	STAT	STAT	STAT	STAT
		1.00	2.00	3.00	4.00	4.01	4.02	4.03	4.04	4.05	4.06	4.07	4.08
		(Adj)	(Adj 9)	(Adj)	(Adj 9)	(Adj)	(Adj)	(Adj)	(Adj)	(Adj)	(Adj)	(Adj)	(Adj)
	GENERAL SERVICE COST CENTERS												
1.00	Old Cap Rel Costs-Bldg & Fixtures												
2.00	Old Cap Rel Costs-Movable Equipment												
3.00	New Cap Rel Costs-Bldg & Fixtures												
4.00	New Cap Rel Costs-Movable Equipment												
4.01													
4.02													
4.03													
4.04													
4.05													
4.06													
4.07													
4.08													
5.00	Employee Benefits	215	215	215	215								
6.01	Non-Patient Telephones												
6.02	Data Processing												
6.03	Purchasing/Receiving												
6.04	Patient Admitting												
6.05	Patient Business Office												
6.06													
6.07													
6.08													
6.00	Administrative and General	2,044	2,044	2,044	2,044								
7.00	Maintenance and Repairs	11,172	11,172	11,172	11,172								
8.00	Operation of Plant	1,774	1,774	1,774	1,774								
9.00	Laundry and Linen Service	923	923	923	923								
10.00	Housekeeping	272	272	272	272								
11.00	Dietary	1,043	1,043	1,043	1,043								
12.00	Cafeteria	420	420	420	420								
13.00	Maintenance of Personnel												
14.00	Nursing Administration	351	351	351	351								
15.00	Central Services & Supply	716	716	716	716								
16.00	Pharmacy	112	112	112	112								
17.00	Medical Records and Library	273	273	273	273								
18.00	Social Service												
19.00													
19.02													
19.03													
20.00													
21.00	Nursing School												
22.00	Intern & Res Service-Salary & Fringes												
23.00	Intern & Res Other Program												
24.00	Paramedical Ed Program												
	INPATIENT ROUTINE COST CENTERS												
25.00	Adults & Pediatrics (Gen Routine)	565	565	565	565								
26.00	Intensive Care Unit												
27.00	Coronary Care Unit												
28.00	Neonatal Intensive Care Unit												
29.00	Surgical Intensive Care												
30.00	Subprovider I												
31.00	Subprovider II												
32.00													
33.00	Nursery												
34.00	Skilled Nursing Facility	6,355	6,355	6,355	6,355								
35.00	Distinct Part Nursing Facility												
36.00	Adult Subacute Care Unit												
36.01	Subacute Care Unit II												
36.02	Transitional Care Unit												

STATE OF CALIFORNIA

STATISTICS FOR COST ALLOCATION (W/S B-1)

SCHEDULE 9

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

		OLD BLDG & FIXTURES (SQ FT)	OLD MOVBLE EQUIP (SQ FT)	NEW BLDG & FIXTURES (SQ FT)	NEW MOVBLE EQUIP (SQ FT)	STAT	STAT	STAT	STAT	STAT	STAT	STAT	STAT
		1.00 (Adj)	2.00 (Adj 9)	3.00 (Adj)	4.00 (Adj 9)	4.01 (Adj)	4.02 (Adj)	4.03 (Adj)	4.04 (Adj)	4.05 (Adj)	4.06 (Adj)	4.07 (Adj)	4.08 (Adj)
	ANCILLARY COST CENTERS												
37.00	Operating Room												
38.00	Recovery Room												
39.00	Delivery Room and Labor Room												
40.00	Anesthesiology												
41.00	Radiology - Diagnostic	968	968	968	968								
41.01													
41.02													
42.00	Radiology - Therapeutic												
43.00	Radioisotope												
44.00	Laboratory	885	885	885	885								
44.01	Pathological Lab												
46.00	Whole Blood												
47.00	Blood Storing and Processing												
48.00	Intravenous Therapy												
49.00	Respiratory Therapy	30	30	30	30								
50.00	Physical Therapy	1,758	1,758	1,758	1,758								
51.00	Occupational Therapy												
52.00	Speech Pathology												
53.00	Electrocardiology												
54.00	Electroencephalography												
55.00	Medical Supplies Charged to Patients												
56.00	Drugs Charged to Patients												
57.00	Renal Dialysis												
58.00	ASC (Non-Distinct Part)												
59.00													
59.01													
59.02													
59.03													
60.00	Clinic												
60.01	Other Clinic Services												
61.00	Emergency	621	1,773	621	1,773								
62.00	Observation Beds												
63.00	Med. Transport												
63.50	Rural Health Clinic		7,350		7,350								
83.00													
84.00													
85.00													
86.00													
	NONREIMBURSABLE COST CENTERS												
96.00	Gift, Flower, Coffee Shop & Canteen												
97.00	Research												
98.00	Physicians' Private Office												
99.00	Nonpaid Workers												
99.01													
99.02													
99.03													
99.04													
99.05													
100.00	Nonreimbursable Meals												
100.01													
100.02													
100.03													
100.04													
	TOTAL	30,497	38,999	30,497	38,999	0	0	0	0	0	0	0	0
	COST TO BE ALLOCATED	0	0	18,848	128,328	0	0	0	0	0	0	0	0
	UNIT COST MULTIPLIER - SCH 8	0.000000	0.000000	0.618028	3.290546	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000

STATE OF CALIFORNIA

STATISTICS FOR COST ALLOCATION (W/S B-1)

SCHEDULE 9.1

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

		EMP BENE (GROSS SALARIES) 5.00 (Adj)	STAT 6.01 (Adj)	STAT 6.02 (Adj)	STAT 6.03 (Adj)	STAT 6.04 (Adj)	STAT 6.05 (Adj)	STAT 6.06 (Adj)	STAT 6.07 (Adj)	STAT 6.08 (Adj)	ADM & GEN (ACCUM COST)	MAINT & REPAIRS (SQ FT) 7.00 (Adj)
	GENERAL SERVICE COST CENTERS											
1.00	Old Cap Rel Costs-Bldg & Fixtures											
2.00	Old Cap Rel Costs-Movable Equipment											
3.00	New Cap Rel Costs-Bldg & Fixtures											
4.00	New Cap Rel Costs-Movable Equipment											
4.01												
4.02												
4.03												
4.04												
4.05												
4.06												
4.07												
4.08												
5.00	Employee Benefits											
6.01	Non-Patient Telephones											
6.02	Data Processing											
6.03	Purchasing/Receiving											
6.04	Patient Admitting											
6.05	Patient Business Office											
6.06												
6.07												
6.08												
6.00	Administrative and General	427,527										
7.00	Maintenance and Repairs	141,987									324,052	
8.00	Operation of Plant										201,842	1,774
9.00	Laundry and Linen Service	35,194									53,653	923
10.00	Housekeeping	125,002									185,024	272
11.00	Dietary	232,419									422,139	1,043
12.00	Cafeteria										1,642	420
13.00	Maintenance of Personnel										0	
14.00	Nursing Administration	72,582									152,383	351
15.00	Central Services & Supply	29,228									45,946	716
16.00	Pharmacy	9,560									15,824	112
17.00	Medical Records and Library	134,872									183,697	273
18.00	Social Service										0	
19.00											0	
19.02											0	
19.03											0	
20.00											0	
21.00	Nursing School										0	
22.00	Intern & Res Service-Salary & Fringes										0	
23.00	Intern & Res Other Program										0	
24.00	Paramedical Ed Program										0	
	INPATIENT ROUTINE COST CENTERS											
25.00	Adults & Pediatrics (Gen Routine)	27,352									148,209	565
26.00	Intensive Care Unit										0	
27.00	Coronary Care Unit										0	
28.00	Neonatal Intensive Care Unit										0	
29.00	Surgical Intensive Care										0	
30.00	Subprovider I										0	
31.00	Subprovider II										0	
32.00											0	
33.00	Nursery										0	
34.00	Skilled Nursing Facility	908,599									1,239,150	6,355
35.00	Distinct Part Nursing Facility										0	
36.00	Adult Subacute Care Unit										0	
36.01	Subacute Care Unit II										0	
36.02	Transitional Care Unit										0	

STATE OF CALIFORNIA

STATISTICS FOR COST ALLOCATION (W/S B-1)

SCHEDULE 9.1

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

		EMP BENE (GROSS SALARIES) 5.00 (Adj)	STAT 6.01 (Adj)	STAT 6.02 (Adj)	STAT 6.03 (Adj)	STAT 6.04 (Adj)	STAT 6.05 (Adj)	STAT 6.06 (Adj)	STAT 6.07 (Adj)	STAT 6.08 (Adj)	ADM & GEN (ACCUM COST)	MAINT & REPAIRS (SQ FT) 7.00 (Adj)
	ANCILLARY COST CENTERS											
37.00	Operating Room										0	
38.00	Recovery Room										0	
39.00	Delivery Room and Labor Room										0	
40.00	Anesthesiology										0	
41.00	Radiology - Diagnostic	217,824									514,036	968
41.01											0	
41.02											0	
42.00	Radiology - Therapeutic										0	
43.00	Radioisotope										0	
44.00	Laboratory	262,209									554,772	885
44.01	Pathological Lab										0	
46.00	Whole Blood										9,163	
47.00	Blood Storing and Processing										0	
48.00	Intravenous Therapy										0	
49.00	Respiratory Therapy	1,279									1,747	30
50.00	Physical Therapy	179,396									253,291	1,758
51.00	Occupational Therapy										0	
52.00	Speech Pathology										0	
53.00	Electrocardiology										0	
54.00	Electroencephalography										0	
55.00	Medical Supplies Charged to Patients										89,755	
56.00	Drugs Charged to Patients										34,723	
57.00	Renal Dialysis										0	
58.00	ASC (Non-Distinct Part)										0	
59.00											0	
59.01											0	
59.02											0	
59.03											0	
60.00	Clinic										0	
60.01	Other Clinic Services										0	
61.00	Emergency	119,201									291,656	621
62.00	Observation Beds										0	
63.00	Med. Transport	3,938									15,199	
63.50	Rural Health Clinic	357,565									757,281	7,350
83.00											0	
84.00											0	
85.00											0	
86.00											0	
	NONREIMBURSABLE COST CENTERS											
96.00	Gift, Flower, Coffee Shop & Canteen										0	
97.00	Research										0	
98.00	Physicians' Private Office										0	
99.00	Nonpaid Workers										0	
99.01											0	
99.02											0	
99.03											0	
99.04											0	
99.05											0	
100.00	Nonreimbursable Meals										0	
100.01											0	
100.02											0	
100.03											0	
100.04											0	
	TOTAL	3,285,734	0	0	0	0	0	0	0	0	5,495,186	24,416
	COST TO BE ALLOCATED	901,915	0	0	0	0	0	0	0	0	767,956	369,339
	UNIT COST MULTIPLIER - SCH 8	0.274494	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.139751	15.126914

STATE OF CALIFORNIA

STATISTICS FOR COST ALLOCATION (W/S B-1)

SCHEDULE 9.2

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

		OPER PLANT (SQ FT) 8.00 (Adj)	LAUNDRY & LINEN (LB LNDRY) 9.00 (Adj)	HOUSE-KEEPING (SQ FT) 10.00 (Adj 9)	DIETARY (MEALS SERVED) 11.00 (Adj 10)	CAFETERIA (PAID FTE'S) 12.00 (Adj)	MAINT OF PERSONNEL (# HOUSED) 13.00 (Adj)	NURSING ADMIN (NURSE HR) 14.00 (Adj)	CENT SERV & SUPPLY (CST REQ) 15.00 (Adj)	PHARMACY (COSTS REQUIS) 16.00 (Adj)	MED REC (TOTAL REVENUE) 17.00 (Adj)	SOC SERV (TIME SPENT) 18.00 (Adj)	STAT 19.00 (Adj)
	GENERAL SERVICE COST CENTERS												
1.00	Old Cap Rel Costs-Bldg & Fixtures												
2.00	Old Cap Rel Costs-Movable Equipment												
3.00	New Cap Rel Costs-Bldg & Fixtures												
4.00	New Cap Rel Costs-Movable Equipment												
4.01													
4.02													
4.03													
4.04													
4.05													
4.06													
4.07													
4.08													
5.00	Employee Benefits												
6.01	Non-Patient Telephones												
6.02	Data Processing												
6.03	Purchasing/Receiving												
6.04	Patient Admitting												
6.05	Patient Business Office												
6.06													
6.07													
6.08													
6.00	Administrative and General												
7.00	Maintenance and Repairs												
8.00	Operation of Plant												
9.00	Laundry and Linen Service	923											
10.00	Housekeeping	272											
11.00	Dietary	1,043		1,043									
12.00	Cafeteria	420		420	2,466								
13.00	Maintenance of Personnel												
14.00	Nursing Administration	351		351		66							
15.00	Central Services & Supply	716	55	716		93							
16.00	Pharmacy	112		112		10							
17.00	Medical Records and Library	273		273		250							
18.00	Social Service												
19.00													
19.02													
19.03													
20.00													
21.00	Nursing School												
22.00	Intern & Res Service-Salary & Fringes												
23.00	Intern & Res Other Program												
24.00	Paramedical Ed Program												
	INPATIENT ROUTINE COST CENTERS												
25.00	Adults & Pediatrics (Gen Routine)	565	52	565	593	56		1,681			51,480		
26.00	Intensive Care Unit												
27.00	Coronary Care Unit												
28.00	Neonatal Intensive Care Unit												
29.00	Surgical Intensive Care												
30.00	Subprovider I												
31.00	Subprovider II												
32.00													
33.00	Nursery												
34.00	Skilled Nursing Facility	6,355	56,848	6,355	34,895	2,411		55,746			3,416,258		
35.00	Distinct Part Nursing Facility												
36.00	Adult Subacute Care Unit												
36.01	Subacute Care Unit II												
36.02	Transitional Care Unit												

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

		OPER PLANT (SQ FT) 8.00 (Adj)	LAUNDRY & LINEN (LB LNDRY) 9.00 (Adj)	HOUSE-KEEPING (SQ FT) 10.00 (Adj 9)	DIETARY (MEALS SERVED) 11.00 (Adj 10)	CAFETERIA (PAID FTE'S) 12.00 (Adj)	MAINT OF PERSONNEL (# HOUSED) 13.00 (Adj)	NURSING ADMIN (NURSE HR) 14.00 (Adj)	CENT SERV & SUPPLY (CST REQ) 15.00 (Adj)	PHARMACY (COSTS REQUIS) 16.00 (Adj)	MED REC (TOTAL REVENUE) 17.00 (Adj)	SOC SERV (TIME SPENT) 18.00 (Adj)	STAT 19.00 (Adj)
	ANCILLARY COST CENTERS												
37.00	Operating Room												
38.00	Recovery Room												
39.00	Delivery Room and Labor Room												
40.00	Anesthesiology												
41.00	Radiology - Diagnostic	968	499	968		530					1,344,172		
41.01													
41.02													
42.00	Radiology - Therapeutic												
43.00	Radioisotope												
44.00	Laboratory	885		885		260					885,130		
44.01	Pathological Lab												
46.00	Whole Blood										3,094		
47.00	Blood Storing and Processing												
48.00	Intravenous Therapy												
49.00	Respiratory Therapy	30		30		2		22			183,337		
50.00	Physical Therapy	1,758	7,347	1,758		360		549			851,932		
51.00	Occupational Therapy												
52.00	Speech Pathology												
53.00	Electrocardiology												
54.00	Electroencephalography												
55.00	Medical Supplies Charged to Patients								100		432,006		
56.00	Drugs Charged to Patients									100	313,012		
57.00	Renal Dialysis												
58.00	ASC (Non-Distinct Part)												
59.00													
59.01													
59.02													
59.03													
60.00	Clinic												
60.01	Other Clinic Services												
61.00	Emergency	621	1,099	1,773		244		9,328			806,599		
62.00	Observation Beds												
63.00	Med. Transport					11					10,866		
63.50	Rural Health Clinic	7,350	572	7,350		416		5,378			741,218		
83.00													
84.00													
85.00													
86.00													
	NONREIMBURSABLE COST CENTERS												
96.00	Gift, Flower, Coffee Shop & Canteen												
97.00	Research												
98.00	Physicians' Private Office												
99.00	Nonpaid Workers												
99.01													
99.02													
99.03													
99.04													
99.05													
100.00	Nonreimbursable Meals				230								
100.01													
100.02													
100.03													
100.04													
	TOTAL	22,642	66,472	22,599	38,184	4,709	0	72,704	100	100	9,039,104	0	0
	COST TO BE ALLOCATED	256,884	85,585	218,082	518,809	50,548	0	187,066	79,300	22,188	221,913	0	0
	UNIT COST MULTIPLIER - SCH 8	11.345485	1.287538	9.650084	13.587087	10.734384	0.000000	2.572986	793.003173	221.883920	0.024550	0.000000	0.000000

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

		STAT	STAT	NONPHY ANESTH (ASG TIME)	NURSE SCHOOL (ASG TIME)	I&R-SAL & FRINGES (ASG TIME)	I&R-PRG COST (ASG TIME)	PARAMED EDUCAT (ASG TIME)
		19.02 (Adj)	19.03 (Adj)	20.00 (Adj)	21.00 (Adj)	22.00 (Adj)	23.00 (Adj)	24.00 (Adj)
	GENERAL SERVICE COST CENTERS							
1.00	Old Cap Rel Costs-Bldg & Fixtures							
2.00	Old Cap Rel Costs-Movable Equipment							
3.00	New Cap Rel Costs-Bldg & Fixtures							
4.00	New Cap Rel Costs-Movable Equipment							
4.01								
4.02								
4.03								
4.04								
4.05								
4.06								
4.07								
4.08								
5.00	Employee Benefits							
6.01	Non-Patient Telephones							
6.02	Data Processing							
6.03	Purchasing/Receiving							
6.04	Patient Admitting							
6.05	Patient Business Office							
6.06								
6.07								
6.08								
6.00	Administrative and General							
7.00	Maintenance and Repairs							
8.00	Operation of Plant							
9.00	Laundry and Linen Service							
10.00	Housekeeping							
11.00	Dietary							
12.00	Cafeteria							
13.00	Maintenance of Personnel							
14.00	Nursing Administration							
15.00	Central Services & Supply							
16.00	Pharmacy							
17.00	Medical Records and Library							
18.00	Social Service							
19.00								
19.02								
19.03								
20.00								
21.00	Nursing School							
22.00	Intern & Res Service-Salary & Fringes							
23.00	Intern & Res Other Program							
24.00	Paramedical Ed Program							
	INPATIENT ROUTINE COST CENTERS							
25.00	Adults & Pediatrics (Gen Routine)							
26.00	Intensive Care Unit							
27.00	Coronary Care Unit							
28.00	Neonatal Intensive Care Unit							
29.00	Surgical Intensive Care							
30.00	Subprovider I							
31.00	Subprovider II							
32.00								
33.00	Nursery							
34.00	Skilled Nursing Facility							
35.00	Distinct Part Nursing Facility							
36.00	Adult Subacute Care Unit							
36.01	Subacute Care Unit II							
36.02	Transitional Care Unit							

STATE OF CALIFORNIA | **STATISTICS FOR COST ALLOCATION (W/S B-1)** | **SCHEDULE 9.3**

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

		STAT	STAT	NONPHY ANESTH (ASG TIME)	NURSE SCHOOL (ASG TIME)	I&R-SAL & FRINGES (ASG TIME)	I&R-PRG COST (ASG TIME)	PARAMED EDUCAT (ASG TIME)
		19.02 (Adj)	19.03 (Adj)	20.00 (Adj)	21.00 (Adj)	22.00 (Adj)	23.00 (Adj)	24.00 (Adj)
	ANCILLARY COST CENTERS							
37.00	Operating Room							
38.00	Recovery Room							
39.00	Delivery Room and Labor Room							
40.00	Anesthesiology							
41.00	Radiology - Diagnostic							
41.01								
41.02								
42.00	Radiology - Therapeutic							
43.00	Radioisotope							
44.00	Laboratory							
44.01	Pathological Lab							
46.00	Whole Blood							
47.00	Blood Storing and Processing							
48.00	Intravenous Therapy							
49.00	Respiratory Therapy							
50.00	Physical Therapy							
51.00	Occupational Therapy							
52.00	Speech Pathology							
53.00	Electrocardiology							
54.00	Electroencephalography							
55.00	Medical Supplies Charged to Patients							
56.00	Drugs Charged to Patients							
57.00	Renal Dialysis							
58.00	ASC (Non-Distinct Part)							
59.00								
59.01								
59.02								
59.03								
60.00	Clinic							
60.01	Other Clinic Services							
61.00	Emergency							
62.00	Observation Beds							
63.00	Med. Transport							
63.50	Rural Health Clinic							
83.00								
84.00								
85.00								
86.00								
	NONREIMBURSABLE COST CENTERS							
96.00	Gift, Flower, Coffee Shop & Canteen							
97.00	Research							
98.00	Physicians' Private Office							
99.00	Nonpaid Workers							
99.01								
99.02								
99.03								
99.04								
99.05								
100.00	Nonreimbursable Meals							
100.01								
100.02								
100.03								
100.04								
	TOTAL	0	0	0	0	0	0	0
	COST TO BE ALLOCATED	0	0	0	0	0	0	0
	UNIT COST MULTIPLIER - SCH 8	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000

STATE OF CALIFORNIA **SCHEDULE 10**

TRIAL BALANCE OF EXPENSES

Provider Name: **Fiscal Period Ended:**
SOUTHERN INYO HOSPITAL **JUNE 30, 2008**

		REPORTED	ADJUSTMENTS (From Sch 10A)	AUDITED
	GENERAL SERVICE COST CENTERS			
1.00	Old Cap Rel Costs-Bldg & Fixtures	$	$ 0	$ 0
2.00	Old Cap Rel Costs-Movable Equipment		0	0
3.00	New Cap Rel Costs-Bldg & Fixtures	0	18,848	18,848
4.00	New Cap Rel Costs-Movable Equipment	159,600	(31,272)	128,328
4.01			0	0
4.02			0	0
4.03			0	0
4.04			0	0
4.05			0	0
4.06			0	0
4.07			0	0
4.08			0	0
5.00	Employee Benefits	901,075	0	901,075
6.01	Non-Patient Telephones		0	0
6.02	Data Processing		0	0
6.03	Purchasing/Receiving		0	0
6.04	Patient Admitting		0	0
6.05	Patient Business Office		0	0
6.06			0	0
6.07			0	0
6.08			0	0
6.00	Administrative and General	757,701	(115,088)	642,613
7.00	Maintenance and Repairs	262,915	(21,504)	241,411
8.00	Operation of Plant	194,908	0	194,908
9.00	Laundry and Linen Service	40,385	0	40,385
10.00	Housekeeping	149,649	0	149,649
11.00	Dietary	354,265	0	354,265
12.00	Cafeteria		0	0
13.00	Maintenance of Personnel		0	0
14.00	Nursing Administration	131,088	0	131,088
15.00	Central Services & Supply	35,125	0	35,125
16.00	Pharmacy	12,762	0	12,762
17.00	Medical Records and Library	145,608	0	145,608
18.00	Social Service		0	0
19.00			0	0
19.02			0	0
19.03			0	0
20.00			0	0
21.00	Nursing School		0	0
22.00	Intern & Res Service-Salary & Fringes		0	0
23.00	Intern & Res Other Program		0	0
24.00	Paramedical Ed Program		0	0
	INPATIENT ROUTINE COST CENTERS			
25.00	Adults & Pediatrics (Gen Routine)	138,493	0	138,493
26.00	Intensive Care Unit		0	0
27.00	Coronary Care Unit		0	0
28.00	Neonatal Intensive Care Unit		0	0
29.00	Surgical Intensive Care		0	0
30.00	Subprovider I		0	0
31.00	Subprovider II		0	0
32.00			0	0
33.00	Nursery		0	0
34.00	Skilled Nursing Facility	975,067	(10,161)	964,906
35.00	Distinct Part Nursing Facility		0	0
36.00	Adult Subacute Care Unit		0	0
36.01	Subacute Care Unit II		0	0
36.02	Transitional Care Unit		0	0

STATE OF CALIFORNIA **SCHEDULE 10**

TRIAL BALANCE OF EXPENSES

Provider Name: **Fiscal Period Ended:**
SOUTHERN INYO HOSPITAL **JUNE 30, 2008**

		REPORTED	ADJUSTMENTS (From Sch 10A)	AUDITED
	ANCILLARY COST CENTERS			
37.00	Operating Room	$	$ 0	$ 0
38.00	Recovery Room		0	0
39.00	Delivery Room and Labor Room		0	0
40.00	Anesthesiology		0	0
41.00	Radiology - Diagnostic	450,461	0	450,461
41.01			0	0
41.02			0	0
42.00	Radiology - Therapeutic		0	0
43.00	Radioisotope		0	0
44.00	Laboratory	479,338	0	479,338
44.01	Pathological Lab		0	0
46.00	Whole Blood	9,163	0	9,163
47.00	Blood Storing and Processing		0	0
48.00	Intravenous Therapy		0	0
49.00	Respiratory Therapy	1,279	0	1,279
50.00	Physical Therapy	197,177	0	197,177
51.00	Occupational Therapy		0	0
52.00	Speech Pathology		0	0
53.00	Electrocardiology		0	0
54.00	Electroencephalography		0	0
55.00	Medical Supplies Charged to Patients	89,755	0	89,755
56.00	Drugs Charged to Patients	34,723	0	34,723
57.00	Renal Dialysis		0	0
58.00	ASC (Non-Distinct Part)		0	0
59.00			0	0
59.01			0	0
59.02			0	0
59.03			0	0
60.00	Clinic		0	0
60.01	Other Clinic Services		0	0
61.00	Emergency	252,718	0	252,718
62.00	Observation Beds		0	0
63.00	Med. Transport	14,118	0	14,118
63.50	Rural Health Clinic	634,946	0	634,946
83.00			0	0
84.00			0	0
85.00			0	0
86.00			0	0
	SUBTOTAL	$ 6,422,319	$ (159,177)	$ 6,263,142
	NONREIMBURSABLE COST CENTERS			
96.00	Gift, Flower, Coffee Shop & Canteen		0	0
97.00	Research		0	0
98.00	Physicians' Private Office		0	0
99.00	Nonpaid Workers		0	0
99.01			0	0
99.02			0	0
99.03			0	0
99.04			0	0
99.05			0	0
100.00	Nonreimbursable Meals	0	0	0
100.01			0	0
100.02			0	0
100.03			0	0
100.04			0	0
100.99	SUBTOTAL	$ 0	$ 0	$ 0
101	TOTAL	$ 6,422,319	$ (159,177)	$ 6,263,142

(To Schedule 8)

STATE OF CALIFORNIA

Provider Name:
SOUTHERN INYO HOSPITAL

ADJUSTMENTS TO REPORTED COSTS

Fiscal Period Ended:
JUNE 30, 2008

Line	Cost Center	TOTAL ADJ (Page 1)	AUDIT ADJ 1	AUDIT ADJ 2	AUDIT ADJ 3	AUDIT ADJ 4	AUDIT ADJ 5	AUDIT ADJ 6	AUDIT ADJ 7	AUDIT ADJ 8	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ
	GENERAL SERVICE COST CENTER													
1.00	Old Cap Rel Costs-Bldg & Fixtures	$0												
2.00	Old Cap Rel Costs-Movable Equipment	0												
3.00	New Cap Rel Costs-Bldg & Fixtures	18,848	18,185							663				
4.00	New Cap Rel Costs-Movable Equipment	(31,272)	(18,185)			(13,087)								
4.01		0												
4.02		0												
4.03		0												
4.04		0												
4.05		0												
4.06		0												
4.07		0												
4.08		0												
5.00	Employee Benefits	0												
6.01	Non-Patient Telephones	0												
6.02	Data Processing	0												
6.03	Purchasing/Receiving	0												
6.04	Patient Admitting	0												
6.05	Patient Business Office	0												
6.06		0												
6.07		0												
6.08		0												
6.00	Administrative and General	(115,088)		(112,809)	(2,279)									
7.00	Maintenance and Repairs	(21,504)							(21,504)					
8.00	Operation of Plant	0												
9.00	Laundry and Linen Service	0												
10.00	Housekeeping	0												
11.00	Dietary	0												
12.00	Cafeteria	0												
13.00	Maintenance of Personnel	0												
14.00	Nursing Administration	0												
15.00	Central Services & Supply	0												
16.00	Pharmacy	0												
17.00	Medical Records and Library	0												
18.00	Social Service	0												
19.00		0												
19.02		0												
19.03		0												
20.00		0												
21.00	Nursing School	0												
22.00	Intern & Res Service-Salary & Fringes	0												
23.00	Intern & Res Other Program	0												
24.00	Paramedical Ed Program	0												
	INPATIENT ROUTINE COST CENTERS													
25.00	Adults & Pediatrics (Gen Routine)	0												
26.00	Intensive Care Unit	0												
27.00	Coronary Care Unit	0												
28.00	Neonatal Intensive Care Unit	0												
29.00	Surgical Intensive Care	0												
30.00	Subprovider I	0												
31.00	Subprovider II	0												
32.00		0												
33.00	Nursery	0												
34.00	Skilled Nursing Facility	(10,161)					(9,281)	(880)						
35.00	Distinct Part Nursing Facility	0												
36.00	Adult Subacute Care Unit	0												
36.01	Subacute Care Unit II	0												
36.02	Transitional Care Unit	0												

STATE OF CALIFORNIA

ADJUSTMENTS TO REPORTED COSTS

SCHEDULE 10A
Page 1

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

		TOTAL ADJ (Page 1)	AUDIT ADJ 1	AUDIT ADJ 2	AUDIT ADJ 3	AUDIT ADJ 4	AUDIT ADJ 5	AUDIT ADJ 6	AUDIT ADJ 7	AUDIT ADJ 8	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ
	ANCILLARY COST CENTERS													
37.00	Operating Room	0												
38.00	Recovery Room	0												
39.00	Delivery Room and Labor Room	0												
40.00	Anesthesiology	0												
41.00	Radiology - Diagnostic	0												
41.01		0												
41.02		0												
42.00	Radiology - Therapeutic	0												
43.00	Radioisotope	0												
44.00	Laboratory	0												
44.01	Pathological Lab	0												
46.00	Whole Blood	0												
47.00	Blood Storing and Processing	0												
48.00	Intravenous Therapy	0												
49.00	Respiratory Therapy	0												
50.00	Physical Therapy	0												
51.00	Occupational Therapy	0												
52.00	Speech Pathology	0												
53.00	Electrocardiology	0												
54.00	Electroencephalography	0												
55.00	Medical Supplies Charged to Patients	0												
56.00	Drugs Charged to Patients	0												
57.00	Renal Dialysis	0												
58.00	ASC (Non-Distinct Part)	0												
59.00		0												
59.01		0												
59.02		0												
59.03		0												
60.00	Clinic	0												
60.01	Other Clinic Services	0												
61.00	Emergency	0												
62.00	Observation Beds	0												
63.00	Med. Transport	0												
63.50	Rural Health Clinic	0												
83.00		0												
84.00		0												
85.00		0												
86.00		0												
	NONREIMBURSABLE COST CENTERS													
96.00	Gift, Flower, Coffee Shop & Canteen	0												
97.00	Research	0												
98.00	Physicians' Private Office	0												
99.00	Nonpaid Workers	0												
99.01		0												
99.02		0												
99.03		0												
99.04		0												
99.05		0												
100.00	Nonreimbursable Meals	0												
100.01		0												
100.02		0												
100.03		0												
100.04		0												
101.00	TOTAL	($159,177) (To Sch 10)	0	(112,809)	(2,279)	(13,087)	(9,281)	(880)	(21,504)	663	0	0	0	0

STATE OF CALIFORNIA

Provider Name:
SOUTHERN INYO HOSPITAL

ADJUSTMENTS TO REPORTED COSTS

SCHEDULE 10A

Fiscal Period Ended:
JUNE 30, 2008

		AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ
	GENERAL SERVICE COST CENTER													
1.00	Old Cap Rel Costs-Bldg & Fixtures													
2.00	Old Cap Rel Costs-Movable Equipment													
3.00	New Cap Rel Costs-Bldg & Fixtures													
4.00	New Cap Rel Costs-Movable Equipment													
4.01														
4.02														
4.03														
4.04														
4.05														
4.06														
4.07														
4.08														
5.00	Employee Benefits													
6.01	Non-Patient Telephones													
6.02	Data Processing													
6.03	Purchasing/Receiving													
6.04	Patient Admitting													
6.05	Patient Business Office													
6.06														
6.07														
6.08														
6.00	Administrative and General													
7.00	Maintenance and Repairs													
8.00	Operation of Plant													
9.00	Laundry and Linen Service													
10.00	Housekeeping													
11.00	Dietary													
12.00	Cafeteria													
13.00	Maintenance of Personnel													
14.00	Nursing Administration													
15.00	Central Services & Supply													
16.00	Pharmacy													
17.00	Medical Records and Library													
18.00	Social Service													
19.00														
19.02														
19.03														
20.00														
21.00	Nursing School													
22.00	Intern & Res Service-Salary & Fringes													
23.00	Intern & Res Other Program													
24.00	Paramedical Ed Program													
	INPATIENT ROUTINE COST CENTERS													
25.00	Adults & Pediatrics (Gen Routine)													
26.00	Intensive Care Unit													
27.00	Coronary Care Unit													
28.00	Neonatal Intensive Care Unit													
29.00	Surgical Intensive Care													
30.00	Subprovider I													
31.00	Subprovider II													
32.00														
33.00	Nursery													
34.00	Skilled Nursing Facility													
35.00	Distinct Part Nursing Facility													
36.00	Adult Subacute Care Unit													
36.01	Subacute Care Unit II													
36.02	Transitional Care Unit													

Provider Name:
SOUTHERN INYO HOSPITAL

Fiscal Period Ended:
JUNE 30, 2008

		AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ	AUDIT ADJ
	ANCILLARY COST CENTERS													
37.00	Operating Room													
38.00	Recovery Room													
39.00	Delivery Room and Labor Room													
40.00	Anesthesiology													
41.00	Radiology - Diagnostic													
41.01														
41.02														
42.00	Radiology - Therapeutic													
43.00	Radioisotope													
44.00	Laboratory													
44.01	Pathological Lab													
46.00	Whole Blood													
47.00	Blood Storing and Processing													
48.00	Intravenous Therapy													
49.00	Respiratory Therapy													
50.00	Physical Therapy													
51.00	Occupational Therapy													
52.00	Speech Pathology													
53.00	Electrocardiology													
54.00	Electroencephalography													
55.00	Medical Supplies Charged to Patients													
56.00	Drugs Charged to Patients													
57.00	Renal Dialysis													
58.00	ASC (Non-Distinct Part)													
59.00														
59.01														
59.02														
59.03														
60.00	Clinic													
60.01	Other Clinic Services													
61.00	Emergency													
62.00	Observation Beds													
63.00	Med. Transport													
63.50	Rural Health Clinic													
83.00														
84.00														
85.00														
86.00														
	NONREIMBURSABLE COST CENTERS													
96.00	Gift, Flower, Coffee Shop & Canteen													
97.00	Research													
98.00	Physicians' Private Office													
99.00	Nonpaid Workers													
99.01														
99.02														
99.03														
99.04														
99.05														
100.00	Nonreimbursable Meals													
100.01														
100.02														
100.03														
100.04														
101.00	TOTAL	0	0	0	0	0	0	0	0	0	0	0	0	0

Provider Name	Fiscal Period	Provider Number	Adjustments
SOUTHERN INYO HOSPITAL	JULY 1, 2007 THROUGH JUNE 30, 2008	ZZT30388F	19

Adj. No.	Audit Report	Work Sheet (Cost Report)	Part (Cost Report)	Title (Cost Report)	Line (Cost Report)	Col. (Cost Report)	Explanation of Audit Adjustments	As Reported	Increase (Decrease)	As Adjusted
							RECLASSIFICATION OF REPORTED COSTS			
1	10A	A			3.00	7	New Capital Related Costs - Building and Fixtures	$0	$18,185	$18,185 *
	10A	A			4.00	7	New Capital Related Costs - Movable Equipment	159,600	(18,185)	141,415 *
							To reclassify capital related costs for proper cost determination.			
							42 CFR 413.5, 413.20 and 413.24			
							CMS Pub. 15-1, Sections 2300 and 2304			
							CMS Pub. 15-2, Section 2408			

*Balance carried forward from prior/to subsequent adjustments

Provider Name	Fiscal Period	Provider Number	Adjustments
SOUTHERN INYO HOSPITAL	JULY 1, 2007 THROUGH JUNE 30, 2008	ZZT30388F	19

Adj. No.	Audit Report	Work Sheet	Cost Report Part	Cost Report Title	Cost Report Line	Cost Report Col.	Explanation of Audit Adjustments		As Reported	Increase (Decrease)	As Adjusted
							ADJUSTMENTS TO REPORTED COSTS				
	10A	A			6.00	7	Administrative and General		$757,701		
2							To adjust the reported expenses to agree with the audited financial statements. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2300 and 2304			($112,809)	
3							To adjust physicians' billing expenses to agree with the provider's general ledger. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2110.4, 2300 and 2304			(2,279) ($115,088)	 $642,613
4	10A	A			4.00	7	New Capital Related Costs - Movable Equipment To adjust depreciation expense to agree with the provider's depreciation schedule. 42 CFR 413.20, 413.24 and 413.134(b)(7) CMS Pub. 15-1, Sections 102 and 2304	*	$141,415	($13,087)	$128,328
	10A	A			34.00	7	Skilled Nursing Facility		$975,067		
5							To eliminate separately billable legend drug costs. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2300 and 2304 CCR, Title 22, Section 51511(c)			($9,281)	
6							To eliminate physicians' travel expenses due to insufficient documentation and because the expense is not included in the payment rate. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2300 and 2304 CCR, Title 22, Section 51511(c)			(880) ($10,161)	 $964,906

*Balance carried forward from prior/to subsequent adjustments

Provider Name							Fiscal Period	Provider Number		Adjustments
SOUTHERN INYO HOSPITAL							JULY 1, 2007 THROUGH JUNE 30, 2008	ZZT30388F		19
Report References										
		Cost Report								
Adj. No.	Audit Report	Work Sheet	Part	Title	Line	Col.	Explanation of Audit Adjustments	As Reported	Increase (Decrease)	As Adjusted
							ADJUSTMENTS TO REPORTED COSTS			
7	10A	A			7.00	7	Maintenance and Repairs To eliminate expense for assets that should have been capitalized. 42 CFR 413.20 and 413.134 CMS Pub. 15-1, Sections 104.3, 108, 2300 and 2304	$262,915	($21,504)	$241,411
8	10A	A			3.00	7	New Capital Related Costs - Building and Fixtures * To include depreciation expense for assets that should have been capitalized in conjunction with adjustment 7. 42 CFR 413.20 and 413.134 CMS Pub. 15-1, Sections 104.3, 108, 2300 and 2304	$18,185	$663	$18,848

*Balance carried forward from prior/to subsequent adjustments

Provider Name							Fiscal Period	Provider Number		Adjustments
SOUTHERN INYO HOSPITAL							JULY 1, 2007 THROUGH JUNE 30, 2008	ZZT30388F		19
Report References										
		Cost Report								
Adj. No.	Audit Report	Work Sheet	Part	Title	Line	Col.	Explanation of Audit Adjustments	As Reported	Increase (Decrease)	As Adjusted
							ADJUSTMENTS TO REPORTED STATISTICS			
9	9	B-1			61.00	2,4,10	Emergency (Square Feet)	621	1,152	1,773
	9	B-1			2.00	2	Total Statistic - Square Feet	37,847	1,152	38,999
	9	B-1			4.00	4	Total Statistic - Square Feet	37,847	1,152	38,999
	9	B-1			10.00	10	Total Statistic - Square Feet	21,447	1,152	22,599
							To adjust square footage statistics to agree with the provider's records and the prior year audit report.			
							42 CFR 413.24 and 413.50			
							CMS Pub. 15-1, Sections 2304 and 2306			
10	9	B-1			12.00	11	Cafeteria (Meals Served)	2,696	(230)	2,466
	9	B-1			25.00	11	Adults and Pediatrics	125	468	593
	9	B-1			34.00	11	Skilled Nursing Facility	35,363	(468)	34,895
	9	B-1			100.00	11	Nonreimbursable Meals	0	230	230
							To reclassify meals served statistics for proper cost determination.			
							42 CFR 413.20, 413.24 and 413.50			
							CMS Pub. 15-1, Sections 2300, 2304 and 2306			

Provider Name							Fiscal Period	Provider Number		Adjustments
SOUTHERN INYO HOSPITAL							JULY 1, 2007 THROUGH JUNE 30, 2008	ZZT30388F		19
Report References										
		Cost Report								
Adj. No.	Audit Report	Work Sheet	Part	Title	Line	Col.	Explanation of Audit Adjustments	As Reported	Increase (Decrease)	As Adjusted
							ADJUSTMENT TO REPORTED PATIENT DAYS			
11	4	D-1	1	XIX	1.00	1	Total Inpatient Days To adjust total patient days to agree with the provider's patient census reports. 42 CFR 413.20, 413.24, and 413.50 CMS Pub. 15-1, Sections 2205, 2300 and 2304	178	22	200

Provider Name							**Fiscal Period**	**Provider Number**		**Adjustments**
SOUTHERN INYO HOSPITAL							JULY 1, 2007 THROUGH JUNE 30, 2008	ZZT30388F		19
Report References										
		Cost Report								
Adj. No.	Audit Report	Work Sheet	Part	Title	Line	Col.	Explanation of Audit Adjustments	As Reported	Increase (Decrease)	As Adjusted
							ADJUSTMENTS TO REPORTED MEDI-CAL SETTLEMENT DATA - SWING-BEDS			
12	4	D-1	1	XIX	5.00	1	Medicare NF Swing Bed Inpatient Days through December 31, 2007	0	55	55
	4	D-1	1	XIX	6.00	1	Medicare NF Swing Bed Inpatient Days after December 31, 2007	82	(55)	27
							To adjust total patient days to agree with census reports and for proper cost reporting. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2205 and 2304			
13	4	D-1	1	XIX	17.00	1	Medicare NF Swing-Bed Rates through December 31, 2007	$0	$1,450.07	$1,450.07
	4	D-1	1	XIX	18.00	1	Medicare NF Swing-Bed Rates after December 31, 2007	0	1,450.07	1,450.07
							To include Medicare swing-bed rates to agree with the critical access hospital instructions and for proper cost determination. 42 CFR 413.53 CMS Pub. 15-1, Section 2230.5 CMS Pub. 15-2, Section 3622.1			
14	4	D-1	1	XIX	7.00	1	Medi-Cal NF Swing-Bed Inpatient Days through July 31, 2007	0	11	11
	4	D-1	1	XIX	8.00	1	Medi-Cal NF Swing-Bed Inpatient Days after July 31, 2007	52	11	63
							To adjust total patient days to agree with the census reports and for proper cost determination. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2205 and 2304			
15	4	D-1	1	XIX	19.00	1	Medi-Cal NF Swing-Bed Rates through July 31, 2007	$144.66	$124.60	$269.26
	4	D-1	1	XIX	20.00	1	Medi-Cal NF Swing-Bed Rates after July 31, 2007	144.66	140.65	285.31
							To include Medi-Cal swing-bed rates to agree with the critical access hospital instructions and for proper cost determination. 42 CFR 413.53 CMS Pub. 15-1, Section 2230.5 CMS Pub. 15-2, Section 3622.1			

Provider Name							Fiscal Period	Provider Number		Adjustments
SOUTHERN INYO HOSPITAL							JULY 1, 2007 THROUGH JUNE 30, 2008	ZZT30388F		19
Report References										
		Cost Report								
Adj. No.	Audit Report	Work Sheet	Part	Title	Line	Col.	Explanation of Audit Adjustments	As Reported	Increase (Decrease)	As Adjusted
							ADJUSTMENT TO REPORTED MEDI-CAL SETTLEMENT DATA - DPNF			
16	DPNF 1	S-3	I	XIX	15.00	5	Medi-Cal Inpatient Days - Skilled Nursing Facility To adjust Medi-Cal days to agree with the following EDS Paid Claims Summary: Report Date: August 12, 2009 Payment Period: July 1, 2007 through July 31, 2009 Service Period: July 1, 2007 through June 30, 2008 42 CFR 413.20, 413.24, 413.50, 413.53, 413.60, 413.64 and 433.139 CMS Pub. 15-1, Sections 2304, 2404 and 2408 CCR, Title 22, Section 51541	7,432	3,621	11,053

Provider Name							Fiscal Period	Provider Number		Adjustments
SOUTHERN INYO HOSPITAL							JULY 1, 2007 THROUGH JUNE 30, 2008	ZZT30388F		19
Report References										
		Cost Report								
Adj. No.	Audit Report	Work Sheet	Part	Title	Line	Col.	Explanation of Audit Adjustments	As Reported	Increase (Decrease)	As Adjusted
							ADJUSTMENTS TO OTHER MATTERS			
17	DPNF 1	N/A					Medi-Cal Credit Balances To recover Medi-Cal credit balances. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2300 and 2304 CCR, Title 22, Sections 50761 and 51458.1	$0	$3,566	$3,566
	DPNF 1	N/A					Medi-Cal Overpayments	$0		
18							To recover Medi-Cal overpayments for improper Part A crossover billings. 42 CFR 413.5 and 413.20 CMS Pub. 15-1, Sections 2300 and 2409 CCR, Title 22, Sections 50761 and 51458.1		$963	
19							To recover Medi-Cal overpayments because the share of cost was not properly deducted from the amount billed and due to insufficient documentation. 42 CFR 413.5, 413.20 and 413.24 CMS Pub. 15-1, Sections 2304 and 2409 CCR, Title 22, Sections 50761, 50786 and 51458.1		2,029 $2,992	$2,992