

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/ 1/2008	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 12/31/2008	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/22/2009 TIME 14:44

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/ 1/2008 AND ENDING 12/31/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

 ECR ENCRYPTION INFORMATION
 DATE: 5/22/2009 TIME 14:44

Jb:sM9qwbyvso5IcaQaGkc.tIJhT40
 au1730zwxazSAarg:ik2by7bMox4be
 DeRy0x03oB05397C

PI ENCRYPTION INFORMATION
 DATE: 5/22/2009 TIME 14:44

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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V		TITLE XVIII		TITLE XIX	
	1	A 2	B 3	4		
1	HOSPITAL	0	182,964	311,845	0	
3	SWING BED - SNF	0	18,311	0	0	
100	TOTAL	0	201,275	311,845	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.

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

FORM APPROVED OMB NO. 0938-0050

WORKSHEET 5 PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY I PROVIDER NO: 14-1327 I PERIOD FROM 1/ 1/2008 TO 12/31/2008 I INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS I DATE RECEIVED: / / I INTERMEDIARY NO: I

ELECTRONICALLY FILED COST REPORT DATE: 5/21/2009 TIME 17:02

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/ 1/2008 AND ENDING 12/31/2008 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

Table with columns: TITLE V, A, B, C, D, E, F, G. Rows: 1 HOSPITAL, 3 SWING BED - SNF, 100 TOTAL. Values: 0, 182,964, 18,311, 201,275, 311,845, 0, 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;

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

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2008 TO: 12/31/2008

18 TYPE OF CONTROL

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL
 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? 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

21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2

21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2

21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER "Y" FOR YES, AND "N" FOR NO. 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 IN COL. 3. / / / /

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

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

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

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

24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy) / /

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

25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R? N

25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?

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

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

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

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

25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)
 26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0
 26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /
 26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /
 27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 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
 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 0.0000 0.0000
 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)

	%	Y/N
28.03 STAFFING	1.00%	Y
28.04 RECRUITMENT	0.00%	
28.05 RETENTION	0.00%	
28.06 TRAINING	0.00%	
28.07	0.00%	
28.08	0.00%	
28.09	0.00%	
28.10	0.00%	
28.11	0.00%	
28.12	0.00%	
28.13	0.00%	
28.14	0.00%	
28.15	0.00%	
28.16	0.00%	
28.17	0.00%	
28.18	0.00%	
28.19	0.00%	
28.20	0.00%	

29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? N
 30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) Y
 30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70 N
 30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS) N
 30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000). N
 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)?

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N
 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 THERE ARE HOME OFFICE COSTS, ENTER IN COL 2 THE HOME OFFICE PROVIDER NUMBER.
 IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION ENTER THE NAME AND ADDRESS OF THE HOME OFFICE N
 40.01 NAME: FI/CONTRACTOR NAME FI/CONTRACTOR #
 40.02 STREET: P.O. BOX:
 40.03 CITY: STATE: ZIP CODE: -
 41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?
 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?
 46 IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF)
 DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

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

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

52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N
 52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV N
 53 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0
 53.01 MDH PERIOD: BEGINNING: / / ENDING: / /
 54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
 PREMIUMS: 0
 PAID LOSSES: 0
 AND/OR SELF INSURANCE: 0
 54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N
 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR, 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N
 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 DATE Y OR N LIMIT Y OR N FEES
 IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 0 1 2 3 4
 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. Y 0.00 N 0
 56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE. 0.00 0
 56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY. 0.00 0
 56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY. 0.00 0

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

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	7,686	58,488.00	3	4	1,881	5
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF						643	
4 ADULTS & PED-SB NF							33
5 TOTAL ADULTS AND PEDS	21	7,686	58,488.00			2,524	149
6 INTENSIVE CARE UNIT	4	1,220	3,576.00			76	14
12 TOTAL	25	8,906	62,064.00			2,600	163
13 RPCH VISITS							
25 TOTAL	25						
26 OBSERVATION BED DAYS							79
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX OBSERVATION BEDS ADMITTED	I/P DAYS / NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	/ TRIPS / TOTAL OBSERVATION BEDS ADMITTED	NOT ADMITTED	-- INTERNS & RES. FTES -- TOTAL	LESS I&R REPL NON-PHYS ANES
1 ADULTS & PEDIATRICS	5.01	5.02	6	6.01	6.02	7	8
2 HMO			2,437				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			643				
4 ADULTS & PED-SB NF			33				
5 TOTAL ADULTS AND PEDS			3,113				
6 INTENSIVE CARE UNIT			149				
12 TOTAL			3,262				
13 RPCH VISITS							
25 TOTAL							
26 OBSERVATION BED DAYS		79	1,166			1,166	
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I & R FTES NET	--- FULL TIME EMPLOYEES ON PAYROLL	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					505	40	690
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					505	40	690
12 TOTAL		180.85					
13 RPCH VISITS							
25 TOTAL		180.85					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

HOSPITAL UNCOMPENSATED CARE DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I WORKSHEET S-10
 I I TO 12/31/2008 I
 I I I

DESCRIPTION

UNCOMPENSATED CARE INFORMATION

1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	
2.01	IS IT AT THE TIME OF ADMISSION?	
2.02	IS IT AT THE TIME OF FIRST BILLING?	
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	
2.04		
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	
4	ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	
5	ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?	
6	ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?	
7	ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?	
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?	
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04	
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	
14	IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02	
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?	
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	
UNCOMPENSATED CARE REVENUES		
17	REVENUE FROM UNCOMPENSATED CARE	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)	.422614
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

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PROVIDER NO:
14-1327

PERIOD:

FROM 1/ 1/2008

TO 12/31/2008

I
I

PREPARED 5/21/2009
WORKSHEET S-10

DESCRIPTION

29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	1,397,753
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)	1,397,753

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I
I 14-1327 I
I

I PERIOD: I
I FROM 1/ 1/2008 I
I TO 12/31/2008 I

I PREPARED 5/21/2009 I
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		369,807	369,807		369,807
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		460,787	460,787	572,095	1,032,882
5	0500 EMPLOYEE BENEFITS	86,685	2,937,563	3,024,248		3,024,248
6	0600 ADMINISTRATIVE & GENERAL	789,173	2,042,500	2,831,673	42,503	2,874,176
8	0800 OPERATION OF PLANT	168,182	597,522	765,704		765,704
10	1000 HOUSEKEEPING	194,149	45,607	239,756		239,756
11	1100 DIETARY	247,158	201,122	448,280	-278,158	170,122
12	1200 CAFETERIA				277,049	277,049
14	1400 NURSING ADMINISTRATION	119,326	12,598	131,924		131,924
17	1700 MEDICAL RECORDS & LIBRARY	241,785	68,955	310,740		310,740
18	1800 SOCIAL SERVICE	99,046	12,313	111,359	-8,688	102,671
20	2000 NONPHYSICIAN ANESTHETISTS	225,630	117,097	342,727	-3,079	339,648
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	1,114,348	263,197	1,377,545	-55,259	1,322,286
26	2600 INTENSIVE CARE UNIT	228,983	51,551	280,534	-41,102	239,432
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	502,393	172,777	675,170	-42,607	632,563
40	4000 ANESTHESIOLOGY					
41	4100 RADIOLOGY-DIAGNOSTIC	536,918	835,063	1,371,981	-160,878	1,211,103
44	4400 LABORATORY	560,608	586,570	1,147,178	-64,352	1,082,826
49	4900 RESPIRATORY THERAPY	324,965	133,993	458,958	-9,600	449,358
50	5000 PHYSICAL THERAPY	351,102	41,160	392,262	-1,265	390,997
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	93,874	1,135,620	1,229,494	192,598	1,422,092
56	5600 DRUGS CHARGED TO PATIENTS	294,109	818,582	1,112,691	4,806	1,117,497
59	3480 ONCOLOGY	78,292	69,753	148,045	-12,847	135,198
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	16,263	4,510	20,773	-16,514	4,259
61	6100 EMERGENCY	834,657	1,296,849	2,131,506	-47,358	2,084,148
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
65	6500 AMBULANCE SERVICES	416,250	84,253	500,503	-17,928	482,575
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		329,416	329,416	-329,416	
95	SUBTOTALS	7,523,896	12,689,165	20,213,061	-0-	20,213,061
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800 PHYSICIANS' PRIVATE OFFICES	1,947,433	855,603	2,803,036		2,803,036
101	TOTAL	9,471,329	13,544,768	23,016,097	-0-	23,016,097

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSESI PROVIDER NO: I
I 14-1327 I
I II PERIOD: I
I FROM 1/ 1/2008 I
I TO 12/31/2008 I
I PREPARED 5/21/2009
I WORKSHEET A

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT		369,807
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-79,812	953,070
5	0500 EMPLOYEE BENEFITS		3,024,248
6	0600 ADMINISTRATIVE & GENERAL	-378,361	2,495,815
8	0800 OPERATION OF PLANT		765,704
10	1000 HOUSEKEEPING		239,756
11	1100 DIETARY	-1,476	168,646
12	1200 CAFETERIA	-79,623	197,426
14	1400 NURSING ADMINISTRATION		131,924
17	1700 MEDICAL RECORDS & LIBRARY	-7,980	302,760
18	1800 SOCIAL SERVICE		102,671
20	2000 NONPHYSICIAN ANESTHETISTS	-304,229	35,419
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS		1,322,286
26	2600 INTENSIVE CARE UNIT		239,432
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM	-416	632,147
40	4000 ANESTHESIOLOGY		
41	4100 RADIOLOGY-DIAGNOSTIC	-7,101	1,204,002
44	4400 LABORATORY	-6,000	1,076,826
49	4900 RESPIRATORY THERAPY	-73,523	375,835
50	5000 PHYSICAL THERAPY		390,997
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	-3,011	1,419,081
56	5600 DRUGS CHARGED TO PATIENTS	-73,497	1,044,000
59	3480 ONCOLOGY		135,198
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC		4,259
61	6100 EMERGENCY	-884,025	1,200,123
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
	OTHER REIMBURS COST CNTRS		
65	6500 AMBULANCE SERVICES		482,575
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
95	SUBTOTALS	-1,899,054	18,314,007
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800 PHYSICIANS' PRIVATE OFFICES		2,803,036
101	TOTAL	-1,899,054	21,117,043

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I NOT A CMS WORKSHEET
 I I TO 12/31/2008 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
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	
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	
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141327	FROM 1/ 1/2008	5/21/2009
	TO 12/31/2008	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1)	COST CENTER	LINE NO	SALARY	OTHER
	1	2	3	4	5
1 RENT	A	NEW CAP REL COSTS-MVBLE EQUIP	4		242,679
2					
3					
4					
5					
6					
7					
8					
9 CAFETERIA	B	CAFETERIA	12	152,750	124,299
10 IV SOLUTIONS	C	DRUGS CHARGED TO PATIENTS	56		4,806
11 MATERIAL MANAGEMENT	D	ADMINISTRATIVE & GENERAL	6		51,621
12 INTEREST	E	NEW CAP REL COSTS-MVBLE EQUIP	4		329,416
13 OXYGEN	F	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		6,046
14					
15					
16					
17 MED SUPPLIES	G	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		242,979
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
36 TOTAL RECLASSIFICATIONS				152,750	1,001,846

(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:
141327

PERIOD:
FROM 1/ 1/2008
TO 12/31/2008

PREPARED 5/21/2009
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 1	6	DECREASE		SALARY 8	OTHER 9	A-7 REF 10
				LINE NO 7				
1 RENT	A			6			9,118	10
2				11			1,109	
3				18			8,688	
4				26			37,425	
5				41			146,780	
6				44			24,233	
7				49			3,326	
8				65			12,000	
9 CAFETERIA	B			11		152,750	124,299	
10 IV SOLUTIONS	C			55			4,806	
11 MATERIAL MANAGEMENT	D			55			51,621	
12 INTEREST	E			88			329,416	11
13 OXYGEN	F			37			172	
14				44			958	
15				49			3,755	
16				65			1,161	
17 MED SUPPLIES	G			20			3,079	
18				25			55,259	
19				26			3,677	
20				37			42,435	
21				41			14,098	
22				44			39,161	
23				49			2,519	
24				50			1,265	
25				59			12,847	
26				60			16,514	
27				61			47,358	
28				65			4,767	
36 TOTAL RECLASSIFICATIONS						152,750	1,001,846	

(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.

RECLASS CODE: A
 EXPLANATION : RENT

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	242,679	ADMINISTRATIVE & GENERAL	6	9,118
2.00			0	DIETARY	11	1,109
3.00			0	SOCIAL SERVICE	18	8,688
4.00			0	INTENSIVE CARE UNIT	26	37,425
5.00			0	RADIOLOGY-DIAGNOSTIC	41	146,780
6.00			0	LABORATORY	44	24,233
7.00			0	RESPIRATORY THERAPY	49	3,326
8.00			0	AMBULANCE SERVICES	65	12,000
TOTAL RECLASSIFICATIONS FOR CODE A			242,679	242,679		

RECLASS CODE: B
 EXPLANATION : CAFETERIA

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	277,049	DIETARY	11	277,049
TOTAL RECLASSIFICATIONS FOR CODE B			277,049	277,049		

RECLASS CODE: C
 EXPLANATION : IV SOLUTIONS

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	56	4,806	MEDICAL SUPPLIES CHARGED TO PA	55	4,806
TOTAL RECLASSIFICATIONS FOR CODE C			4,806	4,806		

RECLASS CODE: D
 EXPLANATION : MATERIAL MANAGEMENT

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	51,621	MEDICAL SUPPLIES CHARGED TO PA	55	51,621
TOTAL RECLASSIFICATIONS FOR CODE D			51,621	51,621		

RECLASS CODE: E
 EXPLANATION : INTEREST

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	329,416	INTEREST EXPENSE	88	329,416
TOTAL RECLASSIFICATIONS FOR CODE E			329,416	329,416		

RECLASS CODE: F
 EXPLANATION : OXYGEN

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	6,046	OPERATING ROOM	37	172
2.00			0	LABORATORY	44	958
3.00			0	RESPIRATORY THERAPY	49	3,755
4.00			0	AMBULANCE SERVICES	65	1,161
TOTAL RECLASSIFICATIONS FOR CODE F			6,046	6,046		

RECLASS CODE: G
 EXPLANATION : MED SUPPLIES

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	242,979	NONPHYSICIAN ANESTHETISTS	20	3,079
2.00			0	ADULTS & PEDIATRICS	25	55,259
3.00			0	INTENSIVE CARE UNIT	26	3,677
4.00			0	OPERATING ROOM	37	42,435
5.00			0	RADIOLOGY-DIAGNOSTIC	41	14,098
6.00			0	LABORATORY	44	39,161
7.00			0	RESPIRATORY THERAPY	49	2,519
8.00			0	PHYSICAL THERAPY	50	1,265
9.00			0	ONCOLOGY	59	12,847
10.00			0	CLINIC	60	16,514
11.00			0	EMERGENCY	61	47,358

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141327	FROM 1/ 1/2008	5/21/2009
	TO 12/31/2008	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	AMBULANCE SERVICES	65	4,767	
TOTAL RECLASSIFICATIONS FOR CODE G			242,979				242,979

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS DONATION 3	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1 LAND	166,949	5,000		5,000		171,949	
2 LAND IMPROVEMENTS	509,682					509,682	
3 BUILDINGS & FIXTURE	12,766,282	1,378,578		1,378,578		14,144,860	
4 BUILDING IMPROVEMEN							
5 FIXED EQUIPMENT	1,334,107	8,903		8,903		1,343,010	
6 MOVABLE EQUIPMENT	6,625,207	224,255		224,255		6,849,462	
7 SUBTOTAL	21,402,227	1,616,736		1,616,736		23,018,963	
8 RECONCILING ITEMS							
9 TOTAL	21,402,227	1,616,736		1,616,736		23,018,963	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	GROSS ASSETS 1	COMPUTATION OF RATIOS		RATIO 4	ALLOCATION OF OTHER CAPITAL			TOTAL 8
			CAPITIALIZED LEASES 2	GROSS ASSETS FOR RATIO 3		INSURANCE 5	TAXES 6	OTHER CAPITAL RELATED COSTS 7	
3	NEW CAP REL COSTS-BL	14,777,021		14,777,021	.690443				
4	NEW CAP REL COSTS-MV	6,625,207		6,625,207	.309557				
5	TOTAL	21,402,228		21,402,228	1.000000				

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	369,807						369,807
4	NEW CAP REL COSTS-MV	380,975	242,679	329,416				953,070
5	TOTAL	750,782	242,679	329,416				1,322,877

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	369,807						369,807
4	NEW CAP REL COSTS-MV	460,787						460,787
5	TOTAL	830,594						830,594

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: I PERIOD:
I 14-1327 I FROM 1/ 1/2008 I PREPARED 5/21/2009
I I TO 12/31/2008 I WORKSHEET A-8

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST. A-7 REF. 5
			COST CENTER	LINE NO	
	1	2	3	4	
1 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	-79,812	NEW CAP REL COSTS-MVBLE E	4	9
5 INVESTMENT INCOME-OTHER					
6 TRADE, QUANTITY AND TIME DISCOUNTS	B	-4,179	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	-970,340			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-79,623	CAFETERIA	12	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS					
18 SALE OF MED AND SURG SUPPLIES	B	-3,011	MEDICAL SUPPLIES CHARGED	55	
19 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-73,497	DRUGS CHARGED TO PATIENTS	56	
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-7,980	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	-1,476	DIETARY	11	
38 SILVER	B	-309	RADIOLOGY-DIAGNOSTIC	41	
39 MISCELLANEOUS	B	-17,274	ADMINISTRATIVE & GENERAL	6	
40 PHYSICIAN RECRUITMENT	A	-115,170	ADMINISTRATIVE & GENERAL	6	
41 PUBLIC RELATIONS	A	-241,738	ADMINISTRATIVE & GENERAL	6	
42 DR AKINTAN	A	-416	OPERATING ROOM	37	
43 CRNA	A	-304,229	NONPHYSICIAN ANESTHETISTS	20	
44					
45 OTHER ADJUSTMENTS (SPECIFY)					
46 OTHER ADJUSTMENTS (SPECIFY)					
47 OTHER ADJUSTMENTS (SPECIFY)					
48 OTHER ADJUSTMENTS (SPECIFY)					
49 OTHER ADJUSTMENTS (SPECIFY)					
50 TOTAL (SUM OF LINES 1 THRU 49)		-1,899,054			

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

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

I PERIOD: I PREPARED 5/21/2009
 I FROM 1/ 1/2008 I WORKSHEET A-8-2
 I TO 12/31/2008 I GROUP 1

LINE NO.	WKSHT A	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	6,792	6,792					
2	44	LAB	6,000	6,000					
3	49	RT	73,523	73,523					
4	61	ER	1,192,502	884,025	308,477				
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL	1,278,817	970,340	308,477				

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I NOT A CMS WORKSHEET
 I I TO 12/31/2008 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 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I WORKSHEET B
 I I TO 12/31/2008 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 &	369,807	369,807					
005 NEW CAP REL COSTS-MVBLE E	953,070		953,070				
006 EMPLOYEE BENEFITS	3,024,248	991	2,554	3,027,793			
008 ADMINISTRATIVE & GENERAL	2,495,815	29,924	77,122	254,613	2,857,474	2,857,474	
010 OPERATION OF PLANT	765,704	17,752	45,752	54,261	883,469	138,256	1,021,725
011 HOUSEKEEPING	239,756	4,445	11,456	62,639	318,296	49,811	14,142
012 DIETARY	168,646	28,239	72,777	30,459	300,121	46,967	89,843
014 CAFETERIA	197,426			49,282	246,708	38,608	
017 NURSING ADMINISTRATION	131,924	2,133	5,497	38,499	178,053	27,864	6,786
018 MEDICAL RECORDS & LIBRARY	302,760	8,023	20,677	78,008	409,468	64,078	25,526
020 SOCIAL SERVICE	102,671	2,649	6,827	31,956	144,103	22,551	8,428
025 NONPHYSICIAN ANESTHETISTS	35,419			72,796	108,215	16,935	
026 INPAT ROUTINE SRVC CNTRS							
ADULTS & PEDIATRICS	1,322,286	69,461	179,016	359,525	1,930,288	302,075	220,997
040 INTENSIVE CARE UNIT	239,432	17,408	44,865	73,877	375,582	58,776	55,386
044 ANCILLARY SRVC COST CNTRS							
OPERATING ROOM	632,147	48,014	123,742	162,089	965,992	151,170	152,760
041 ANESTHESIOLOGY							
RADIOLOGY-DIAGNOSTIC	1,204,002	33,633	86,680	173,227	1,497,542	234,353	107,006
044 LABORATORY	1,076,826	6,936	17,875	180,871	1,282,508	200,702	22,067
049 RESPIRATORY THERAPY	375,835	7,638	19,684	104,844	508,001	79,498	24,300
050 PHYSICAL THERAPY	390,997	14,532	37,452	113,277	556,258	87,050	46,235
055 MEDICAL SUPPLIES CHARGED	1,419,081	9,124	23,514	30,287	1,482,006	231,922	29,028
056 DRUGS CHARGED TO PATIENTS	1,044,000	3,482	8,973	94,889	1,151,344	180,176	11,077
059 ONCOLOGY	135,198	6,888	17,751	25,260	185,097	28,966	21,913
060 OUTPAT SERVICE COST CNTRS							
CLINIC	4,259			5,247	9,506	1,488	
061 EMERGENCY	1,200,123	22,590	58,218	269,288	1,550,219	242,597	71,870
062 OBSERVATION BEDS (NON-DIS							
OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES	482,575	24,551	63,272	134,296	704,694	110,279	78,109
095 SPEC PURPOSE COST CENTERS							
SUBTOTALS	18,314,007	358,413	923,704	2,399,490	17,644,944	2,314,122	985,473
096 NONREIMBURS COST CENTERS							
GIFT, FLOWER, COFFEE SHOP		1,761	4,540		6,301	986	5,604
098 PHYSICIANS' PRIVATE OFFIC	2,803,036	9,633	24,826	628,303	3,465,798	542,366	30,648
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	21,117,043	369,807	953,070	3,027,793	21,117,043	2,857,474	1,021,725

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINISTRATION 14	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	NONPHYSICIAN ANESTHETISTS 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 OPERATION OF PLANT							
010 HOUSEKEEPING	382,249						
011 DIETARY	5,573	442,504					
012 CAFETERIA			285,316				
014 NURSING ADMINISTRATION			3,190	215,893			
017 MEDICAL RECORDS & LIBRARY			18,799		517,871		
018 SOCIAL SERVICE			4,516			179,598	
020 NONPHYSICIAN ANESTHETISTS			2,479				127,629
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	200,549	423,242	58,555	100,062	450,599	171,780	
ANCILLARY SRVC COST CNTRS		19,262	9,350	15,978	30,192	7,818	
037 OPERATING ROOM	52,683		21,179	36,192			
040 ANESTHESIOLOGY							127,629
041 RADIOLOGY-DIAGNOSTIC	32,301		24,664				
044 LABORATORY	1,858		24,369				
049 RESPIRATORY THERAPY	258		16,369				
050 PHYSICAL THERAPY	18,748		13,743				
055 MEDICAL SUPPLIES CHARGED			2,528				
056 DRUGS CHARGED TO PATIENTS			10,749				
059 ONCOLOGY			3,534				
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC			4,417				
062 EMERGENCY	69,436		37,254	63,661	37,080		
065 OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS)	843		29,621				
095 SPEC PURPOSE COST CENTERS	382,249	442,504	285,316	215,893	517,871	179,598	127,629
096 SUBTOTALS							
098 NONREIMBURS COST CENTERS							
099 GIFT, FLOWER, COFFEE SHOP							
100 PHYSICIANS' PRIVATE OFFIC							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	382,249	442,504	285,316	215,893	517,871	179,598	127,629

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I WORKSHEET B
 I TO 12/31/2008 I PART I

	COST CENTER DESCRIPTION	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
		25	26	27
	GENERAL SERVICE COST CNTR			
003	NEW CAP REL COSTS-BLDG &			
004	NEW CAP REL COSTS-MVBLE E			
005	EMPLOYEE BENEFITS			
006	ADMINISTRATIVE & GENERAL			
008	OPERATION OF PLANT			
010	HOUSEKEEPING			
011	DIETARY			
012	CAFETERIA			
014	NURSING ADMINISTRATION			
017	MEDICAL RECORDS & LIBRARY			
018	SOCIAL SERVICE			
020	NONPHYSICIAN ANESTHETISTS			
	INPAT ROUTINE SRVC CNTRS			
025	ADULTS & PEDIATRICS	3,858,147		3,858,147
026	INTENSIVE CARE UNIT	572,344		572,344
	ANCILLARY SRVC COST CNTRS			
	OPERATING ROOM	1,379,976		1,379,976
040	ANESTHESIOLOGY	127,629		127,629
041	RADIOLOGY-DIAGNOSTIC	1,895,866		1,895,866
044	LABORATORY	1,531,504		1,531,504
049	RESPIRATORY THERAPY	628,426		628,426
050	PHYSICAL THERAPY	722,034		722,034
055	MEDICAL SUPPLIES CHARGED	1,745,484		1,745,484
056	DRUGS CHARGED TO PATIENTS	1,353,346		1,353,346
059	ONCOLOGY	239,510		239,510
	OUTPAT SERVICE COST CNTRS			
060	CLINIC	15,411		15,411
061	EMERGENCY	2,072,117		2,072,117
062	OBSERVATION BEDS (NON-DIS			
	OTHER REIMBURS COST CNTRS			
065	AMBULANCE SERVICES	923,546		923,546
	SPEC PURPOSE COST CENTERS			
095	SUBTOTALS	17,065,340		17,065,340
	NONREIMBURS COST CENTERS			
096	GIFT, FLOWER, COFFEE SHOP	12,891		12,891
098	PHYSICIANS' PRIVATE OFFIC	4,038,812		4,038,812
101	CROSS FOOT ADJUSTMENT			
102	NEGATIVE COST CENTER			
103	TOTAL	21,117,043		21,117,043

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I WORKSHEET B
 I I TO 12/31/2008 I PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS 0	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-MVBLE E 4	SUBTOTAL 4a	EMPLOYEE BENE FITS 5	ADMINISTRATIV E & GENERAL 6	OPERATION OF PLANT 8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS		991	2,554	3,545	3,545		
008 ADMINISTRATIVE & GENERAL		29,924	77,122	107,046	298	107,344	
010 OPERATION OF PLANT		17,752	45,752	63,504	64	5,194	68,762
011 HOUSEKEEPING		4,445	11,456	15,901	73	1,871	952
012 DIETARY		28,239	72,777	101,016	36	1,764	6,046
014 CAFETERIA					58	1,450	
017 NURSING ADMINISTRATION		2,133	5,497	7,630	45	1,047	457
018 MEDICAL RECORDS & LIBRARY		8,023	20,677	28,700	91	2,407	1,718
020 SOCIAL SERVICE		2,649	6,827	9,476	37	847	567
025 NONPHYSICIAN ANESTHETISTS					85	636	
026 INPAT ROUTINE SRVC CNTRS							
037 ADULTS & PEDIATRICS		69,461	179,016	248,477	421	11,348	14,872
040 INTENSIVE CARE UNIT		17,408	44,865	62,273	87	2,208	3,727
041 ANCILLARY SRVC COST CNTRS							
044 OPERATING ROOM		48,014	123,742	171,756	190	5,679	10,281
049 ANESTHESIOLOGY							
050 RADIOLOGY-DIAGNOSTIC		33,633	86,680	120,313	203	8,804	7,202
055 LABORATORY		6,936	17,875	24,811	212	7,540	1,485
056 RESPIRATORY THERAPY		7,638	19,684	27,322	123	2,987	1,635
059 PHYSICAL THERAPY		14,532	37,452	51,984	133	3,270	3,112
060 MEDICAL SUPPLIES CHARGED		9,124	23,514	32,638	35	8,713	1,954
061 DRUGS CHARGED TO PATIENTS		3,482	8,973	12,455	111	6,769	745
062 ONCOLOGY		6,888	17,751	24,639	30	1,088	1,475
065 OUTPAT SERVICE COST CNTRS							
095 CLINIC					6	56	
096 EMERGENCY		22,590	58,218	80,808	316	9,114	4,837
098 OBSERVATION BEDS (NON-DIS							
101 OTHER REIMBURS COST CNTRS							
102 AMBULANCE SERVICES		24,551	63,272	87,823	157	4,143	5,257
103 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS		358,413	923,704	1,282,117	2,811	86,935	66,322
096 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP		1,761	4,540	6,301		37	377
101 PHYSICIANS' PRIVATE OFFIC		9,633	24,826	34,459	734	20,372	2,063
102 CROSS FOOT ADJUSTMENTS							
103 NEGATIVE COST CENTER							
103 TOTAL		369,807	953,070	1,322,877	3,545	107,344	68,762

ALLOCATION OF NEW CAPITAL RELATED COSTS

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	18,797						
012 DIETARY	274	109,136					
014 CAFETERIA			1,508				
017 NURSING ADMINISTRATION			17	9,196			
018 MEDICAL RECORDS & LIBRARY			99		33,015		
020 SOCIAL SERVICE			24			10,951	
025 NONPHYSICIAN ANESTHETISTS			13				734
026 INPAT ROUTINE SRVC CNTRS							
ADULTS & PEDIATRICS	9,863	104,385	309	4,261	28,726	10,474	
INTENSIVE CARE UNIT		4,751	49	681	1,925	477	
037 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM	2,591		112	1,542			
041 ANESTHESIOLOGY							
044 RADIOLOGY-DIAGNOSTIC	1,588		130				
049 LABORATORY	91		129				
050 RESPIRATORY THERAPY	13		87				
055 PHYSICAL THERAPY	922		73				
056 MEDICAL SUPPLIES CHARGED			13				
059 DRUGS CHARGED TO PATIENTS			57				
ONCOLOGY			19				
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC			23				
062 EMERGENCY	3,414		197	2,712	2,364		
065 OBSERVATION BEDS (NON-DIS							
OTHER REIMBURS COST CNTRS							
AMBULANCE SERVICES	41		157				
095 SPEC PURPOSE COST CENTERS							
SUBTOTALS	18,797	109,136	1,508	9,196	33,015	10,951	
096 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP							
101 PHYSICIANS' PRIVATE OFFIC							734
102 CROSS FOOT ADJUSTMENTS							
103 NEGATIVE COST CENTER							
TOTAL	18,797	109,136	1,508	9,196	33,015	10,951	734

ALLOCATION OF NEW CAPITAL RELATED COSTS

	COST CENTER DESCRIPTION	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		25	26	27
	GENERAL SERVICE COST CNTR			
003	NEW CAP REL COSTS-BLDG &			
004	NEW CAP REL COSTS-MVBLE E			
005	EMPLOYEE BENEFITS			
006	ADMINISTRATIVE & GENERAL			
008	OPERATION OF PLANT			
010	HOUSEKEEPING			
011	DIETARY			
012	CAFETERIA			
014	NURSING ADMINISTRATION			
017	MEDICAL RECORDS & LIBRARY			
018	SOCIAL SERVICE			
020	NONPHYSICIAN ANESTHETISTS			
	INPAT ROUTINE SRVC CNTRS			
025	ADULTS & PEDIATRICS	433,136		433,136
026	INTENSIVE CARE UNIT	76,178		76,178
	ANCILLARY SRVC COST CNTRS			
037	OPERATING ROOM	192,151		192,151
040	ANESTHESIOLOGY			
041	RADIOLOGY-DIAGNOSTIC	138,240		138,240
044	LABORATORY	34,268		34,268
049	RESPIRATORY THERAPY	32,167		32,167
050	PHYSICAL THERAPY	59,494		59,494
055	MEDICAL SUPPLIES CHARGED	43,353		43,353
056	DRUGS CHARGED TO PATIENTS	20,137		20,137
059	ONCOLOGY	27,251		27,251
	OUTPAT SERVICE COST CNTRS			
060	CLINIC	85		85
061	EMERGENCY	103,762		103,762
062	OBSERVATION BEDS (NON-DIS			
	OTHER REIMBURS COST CNTRS			
065	AMBULANCE SERVICES	97,578		97,578
	SPEC PURPOSE COST CENTERS			
095	SUBTOTALS	1,257,800		1,257,800
	NONREIMBURS COST CENTERS			
096	GIFT, FLOWER, COFFEE SHOP	6,715		6,715
098	PHYSICIANS' PRIVATE OFFIC	57,628		57,628
101	CROSS FOOT ADJUSTMENTS	734		734
102	NEGATIVE COST CENTER			
103	TOTAL	1,322,877		1,322,877

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I WORKSHEET B-1
 I I TO 12/31/2008 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	53,745					
005	NEW CAP REL COSTS-MVB		53,745				
006	EMPLOYEE BENEFITS	144	144	9,384,644			
008	ADMINISTRATIVE & GENE	4,349	4,349	789,173	-2,857,474	18,259,569	
010	OPERATION OF PLANT	2,580	2,580	168,182		883,469	46,672
011	HOUSEKEEPING	646	646	194,149		318,296	646
012	DIETARY	4,104	4,104	94,408		300,121	4,104
014	CAFETERIA			152,750		246,708	
017	NURSING ADMINISTRATIO	310	310	119,326		178,053	310
018	MEDICAL RECORDS & LIB	1,166	1,166	241,785		409,468	1,166
020	SOCIAL SERVICE	385	385	99,046		144,103	385
025	NONPHYSICIAN ANESTHET			225,630		108,215	
026	INPAT ROUTINE SRVC CN						
026	ADULTS & PEDIATRICS	10,095	10,095	1,114,348		1,930,288	10,095
037	INTENSIVE CARE UNIT	2,530	2,530	228,983		375,582	2,530
040	ANCILLARY SRVC COST C						
040	OPERATING ROOM	6,978	6,978	502,393		965,992	6,978
041	ANESTHESIOLOGY						
041	RADIOLOGY-DIAGNOSTIC	4,888	4,888	536,918		1,497,542	4,888
044	LABORATORY	1,008	1,008	560,608		1,282,508	1,008
049	RESPIRATORY THERAPY	1,110	1,110	324,965		508,001	1,110
050	PHYSICAL THERAPY	2,112	2,112	351,102		556,258	2,112
055	MEDICAL SUPPLIES CHAR	1,326	1,326	93,874		1,482,006	1,326
056	DRUGS CHARGED TO PATI	506	506	294,109		1,151,344	506
059	ONCOLOGY	1,001	1,001	78,292		185,097	1,001
060	OUTPAT SERVICE COST C						
061	CLINIC			16,263		9,506	
061	EMERGENCY	3,283	3,283	834,657		1,550,219	3,283
062	OBSERVATION BEDS (NON						
065	OTHER REIMBURS COST C						
065	AMBULANCE SERVICES	3,568	3,568	416,250		704,694	3,568
095	SPEC PURPOSE COST CEN						
095	SUBTOTALS	52,089	52,089	7,437,211	-2,857,474	14,787,470	45,016
096	NONREIMBURS COST CENT						
098	GIFT, FLOWER, COFFEE	256	256			6,301	256
101	PHYSICIANS' PRIVATE O	1,400	1,400	1,947,433		3,465,798	1,400
102	CROSS FOOT ADJUSTMENT						
102	NEGATIVE COST CENTER						
103	COST TO BE ALLOCATED	369,807	953,070	3,027,793		2,857,474	1,021,725
104	(WRKSHT B, PART I)						
104	UNIT COST MULTIPLIER	6.880770		.322633		.156492	
105	(WRKSHT B, PT I)		17.733184				21.891605
106	COST TO BE ALLOCATED						
106	(WRKSHT B, PART II)						
106	UNIT COST MULTIPLIER						
107	(WRKSHT B, PT II)			3,545		107,344	68,762
107	COST TO BE ALLOCATED						
107	(WRKSHT B, PART III)						
108	UNIT COST MULTIPLIER			.000378		.005879	
108	(WRKSHT B, PT III)						1.473303

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I WORKSHEET B-1
 I I TO 12/31/2008 I

	COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN	MEDICAL RECOR	SOCIAL SERVIC	NONPHYSICIAN
		(POUNDS	(MEALS	S(FTE'S	(NURSE FTE'S	(TIME	(DAYS	(ASSIGNED
))ERVED)))SPENT)) 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	22,224						
012	DIETARY	324	9,993					
014	CAFETERIA			11,626				
017	NURSING ADMINISTRATIO			130	5,148			
018	MEDICAL RECORDS & LIB			766		10,000		
020	SOCIAL SERVICE			184			3,331	
025	NONPHYSICIAN ANESTHET			101				100
026	INPAT ROUTINE SRVC CN							
026	ADULTS & PEDIATRICS	11,660	9,558	2,386	2,386	8,701	3,186	
037	INTENSIVE CARE UNIT		435	381	381	583	145	
040	ANCILLARY SRVC COST C							
041	OPERATING ROOM	3,063		863	863			
044	ANESTHESIOLOGY							100
049	RADIOLOGY-DIAGNOSTIC	1,878		1,005				
050	LABORATORY	108		993				
055	RESPIRATORY THERAPY	15		667				
056	PHYSICAL THERAPY	1,090		560				
059	MEDICAL SUPPLIES CHAR			103				
060	DRUGS CHARGED TO PATI			438				
061	ONCOLOGY			144				
062	OUTPAT SERVICE COST C							
065	CLINIC			180				
095	EMERGENCY	4,037		1,518	1,518	716		
098	OBSERVATION BEDS (NON							
101	OTHER REIMBURS COST C							
102	AMBULANCE SERVICES	49		1,207				
103	SPEC PURPOSE COST CEN							
104	SUBTOTALS	22,224	9,993	11,626	5,148	10,000	3,331	100
105	NONREIMBURS COST CENT							
106	GIFT, FLOWER, COFFEE							
107	PHYSICIANS' PRIVATE O							
108	CROSS FOOT ADJUSTMENT							
109	NEGATIVE COST CENTER							
110	COST TO BE ALLOCATED	382,249	442,504	285,316	215,893	517,871	179,598	127,629
111	(WRKSHT B, PART I)							
112	UNIT COST MULTIPLIER		44.281397		41.937257		53.917142	
113	(WRKSHT B, PT I)	17.199829		24.541201		51.787100		1,276.290000
114	COST TO BE ALLOCATED							
115	(WRKSHT B, PART II)							
116	UNIT COST MULTIPLIER							
117	(WRKSHT B, PT II)							
118	COST TO BE ALLOCATED	18,797	109,136	1,508	9,196	33,015	10,951	734
119	(WRKSHT B, PART III)							
120	UNIT COST MULTIPLIER		10.921245		1.786325		3.287601	
121	(WRKSHT B, PT III)	.845797		.129709		3.301500		7.340000

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	3,858,147		3,858,147		
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS	572,344		572,344		
37	OPERATING ROOM	1,379,976		1,379,976		
40	ANESTHESIOLOGY	127,629		127,629		
41	RADIOLOGY-DIAGNOSTIC	1,895,866		1,895,866		
44	LABORATORY	1,531,504		1,531,504		
49	RESPIRATORY THERAPY	628,426		628,426		
50	PHYSICAL THERAPY	722,034		722,034		
55	MEDICAL SUPPLIES CHARGED	1,745,484		1,745,484		
56	DRUGS CHARGED TO PATIENTS	1,353,346		1,353,346		
59	ONCOLOGY	239,510		239,510		
60	OUTPAT SERVICE COST CNTRS CLINIC	15,411		15,411		
61	EMERGENCY	2,072,117		2,072,117		
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	1,058,681		1,058,681		
65	AMBULANCE SERVICES	923,546		923,546		
101	SUBTOTAL	18,124,021		18,124,021		
102	LESS OBSERVATION BEDS	1,058,681		1,058,681		
103	TOTAL	17,065,340		17,065,340		

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I WORKSHEET C
 I I TO 12/31/2008 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	2,459,271		2,459,271			
26	INTENSIVE CARE UNIT	130,028		130,028			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	854,477	3,640,101	4,494,578	.307031	.307031	
40	ANESTHESIOLOGY	299,608	786,685	1,086,293	.117490	.117490	
41	RADIOLOGY-DIAGNOSTIC	683,302	9,077,305	9,760,607	.194236	.194236	
44	LABORATORY	2,590,748	5,418,536	8,009,284	.191216	.191216	
49	RESPIRATORY THERAPY	797,187	1,290,280	2,087,467	.301047	.301047	
50	PHYSICAL THERAPY	264,549	934,427	1,198,976	.602209	.602209	
55	MEDICAL SUPPLIES CHARGED	1,382,389	929,855	2,312,244	.754887	.754887	
56	DRUGS CHARGED TO PATIENTS	1,381,744	2,019,432	3,401,176	.397905	.397905	
59	ONCOLOGY		164,052	164,052	1.459964	1.459964	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		26,223	26,223	.587690	.587690	
61	EMERGENCY	47,774	3,265,147	3,312,921	.625465	.625465	
62	OBSERVATION BEDS (NON-DIS		697,063	697,063	1.518774	1.518774	
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		1,240,303	1,240,303	.744613	.744613	
101	SUBTOTAL	10,891,077	29,489,409	40,380,486			
102	LESS OBSERVATION BEDS						
103	TOTAL	10,891,077	29,489,409	40,380,486			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I
I
I

PROVIDER NO:
14-1327

I PERIOD:
I FROM 1/ 1/2008
I TO 12/31/2008

I PREPARED 5/21/2009
I WORKSHEET C
I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS					
	ADULTS & PEDIATRICS	3,858,147		3,858,147		
26	INTENSIVE CARE UNIT	572,344		572,344		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,379,976		1,379,976		
40	ANESTHESIOLOGY	127,629		127,629		
41	RADIOLOGY-DIAGNOSTIC	1,895,866		1,895,866		
44	LABORATORY	1,531,504		1,531,504		
49	RESPIRATORY THERAPY	628,426		628,426		
50	PHYSICAL THERAPY	722,034		722,034		
55	MEDICAL SUPPLIES CHARGED	1,745,484		1,745,484		
56	DRUGS CHARGED TO PATIENTS	1,353,346		1,353,346		
59	ONCOLOGY	239,510		239,510		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	15,411		15,411		
61	EMERGENCY	2,072,117		2,072,117		
62	OBSERVATION BEDS (NON-DIS	1,058,681		1,058,681		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	923,546		923,546		
101	SUBTOTAL	18,124,021		18,124,021		
102	LESS OBSERVATION BEDS	1,058,681		1,058,681		
103	TOTAL	17,065,340		17,065,340		

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/21/2009
I 14-1327 I FROM 1/ 1/2008 I WORKSHEET C
I I TO 12/31/2008 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	2,459,271		2,459,271			
26	INTENSIVE CARE UNIT	130,028		130,028			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	854,477	3,640,101	4,494,578	.307031	.307031	
40	ANESTHESIOLOGY	299,608	786,685	1,086,293	.117490	.117490	
41	RADIOLOGY-DIAGNOSTIC	683,302	9,077,305	9,760,607	.194236	.194236	
44	LABORATORY	2,590,748	5,418,536	8,009,284	.191216	.191216	
49	RESPIRATORY THERAPY	797,187	1,290,280	2,087,467	.301047	.301047	
50	PHYSICAL THERAPY	264,549	934,427	1,198,976	.602209	.602209	
55	MEDICAL SUPPLIES CHARGED	1,382,389	929,855	2,312,244	.754887	.754887	
56	DRUGS CHARGED TO PATIENTS	1,381,744	2,019,432	3,401,176	.397905	.397905	
59	ONCOLOGY		164,052	164,052	1.459964	1.459964	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		26,223	26,223	.587690	.587690	
61	EMERGENCY	47,774	3,265,147	3,312,921	.625465	.625465	
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS		697,063	697,063	1.518774	1.518774	
65	AMBULANCE SERVICES		1,240,303	1,240,303	.744613	.744613	
101	SUBTOTAL	10,891,077	29,489,409	40,380,486			
102	LESS OBSERVATION BEDS						
103	TOTAL	10,891,077	29,489,409	40,380,486			

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	1,379,976	192,151	1,187,825			1,379,976
40	ANESTHESIOLOGY	127,629		127,629			127,629
41	RADIOLOGY-DIAGNOSTIC	1,895,866	138,240	1,757,626			1,895,866
44	LABORATORY	1,531,504	34,268	1,497,236			1,531,504
49	RESPIRATORY THERAPY	628,426	32,167	596,259			628,426
50	PHYSICAL THERAPY	722,034	59,494	662,540			722,034
55	MEDICAL SUPPLIES CHARGED	1,745,484	43,353	1,702,131			1,745,484
56	DRUGS CHARGED TO PATIENTS	1,353,346	20,137	1,333,209			1,353,346
59	ONCOLOGY	239,510	27,251	212,259			239,510
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	15,411	85	15,326			15,411
61	EMERGENCY	2,072,117	103,762	1,968,355			2,072,117
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	1,058,681		1,058,681			1,058,681
65	AMBULANCE SERVICES	923,546	97,578	825,968			923,546
101	SUBTOTAL	13,693,530	748,486	12,945,044			13,693,530
102	LESS OBSERVATION BEDS	1,058,681		1,058,681			1,058,681
103	TOTAL	12,634,849	748,486	11,886,363			12,634,849

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	4,494,578	.307031	.307031
40	ANESTHESIOLOGY	1,086,293	.117490	.117490
41	RADIOLOGY-DIAGNOSTIC	9,760,607	.194236	.194236
44	LABORATORY	8,009,284	.191216	.191216
49	RESPIRATORY THERAPY	2,087,467	.301047	.301047
50	PHYSICAL THERAPY	1,198,976	.602209	.602209
55	MEDICAL SUPPLIES CHARGED	2,312,244	.754887	.754887
56	DRUGS CHARGED TO PATIENTS	3,401,176	.397905	.397905
59	ONCOLOGY	164,052	1.459964	1.459964
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	26,223	.587690	.587690
61	EMERGENCY	3,312,921	.625465	.625465
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	697,063	1.518774	1.518774
65	AMBULANCE SERVICES	1,240,303	.744613	.744613
101	SUBTOTAL	37,791,187		
102	LESS OBSERVATION BEDS	697,063		
103	TOTAL	37,094,124		

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	1,379,976	192,151	1,187,825			1,379,976
40	ANESTHESIOLOGY	127,629		127,629			127,629
41	RADIOLOGY-DIAGNOSTIC	1,895,866	138,240	1,757,626			1,895,866
44	LABORATORY	1,531,504	34,268	1,497,236			1,531,504
49	RESPIRATORY THERAPY	628,426	32,167	596,259			628,426
50	PHYSICAL THERAPY	722,034	59,494	662,540			722,034
55	MEDICAL SUPPLIES CHARGED	1,745,484	43,353	1,702,131			1,745,484
56	DRUGS CHARGED TO PATIENTS	1,353,346	20,137	1,333,209			1,353,346
59	ONCOLOGY	239,510	27,251	212,259			239,510
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	15,411	85	15,326			15,411
61	EMERGENCY	2,072,117	103,762	1,968,355			2,072,117
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	1,058,681		1,058,681			1,058,681
65	AMBULANCE SERVICES	923,546	97,578	825,968			923,546
101	SUBTOTAL	13,693,530	748,486	12,945,044			13,693,530
102	LESS OBSERVATION BEDS	1,058,681		1,058,681			1,058,681
103	TOTAL	12,634,849	748,486	11,886,363			12,634,849

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL
 CALCULATION OF OUTPATIENT SERVICE COST TO I PROVIDER NO:
 CHARGE RATIOS NET OF REDUCTIONS I 14-1327
 SPECIAL TITLE XIX WORKSHEET I

**NOT A CMS WORKSHEET ** (09/2000)
 I PERIOD: I PREPARED 5/21/2009
 I FROM 1/ 1/2008 I WORKSHEET C
 I TO 12/31/2008 I PART II

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	4,494,578	.307031	.307031
40	ANESTHESIOLOGY	1,086,293	.117490	.117490
41	RADIOLOGY-DIAGNOSTIC	9,760,607	.194236	.194236
44	LABORATORY	8,009,284	.191216	.191216
49	RESPIRATORY THERAPY	2,087,467	.301047	.301047
50	PHYSICAL THERAPY	1,198,976	.602209	.602209
55	MEDICAL SUPPLIES CHARGED	2,312,244	.754887	.754887
56	DRUGS CHARGED TO PATIENTS	3,401,176	.397905	.397905
59	ONCOLOGY	164,052	1.459964	1.459964
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	26,223	.587690	.587690
61	EMERGENCY	3,312,921	.625465	.625465
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	697,063	1.518774	1.518774
65	AMBULANCE SERVICES	1,240,303	.744613	.744613
101	SUBTOTAL	37,791,187		
102	LESS OBSERVATION BEDS	697,063		
103	TOTAL	37,094,124		

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
	ANCILLARY SRVC COST CNTRS					
37	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			
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			
	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 5/21/2009
I 14-1327 I FROM 1/ 1/2008 I WORKSHEET C
I I TO 12/31/2008 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			
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			
	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 Radiology
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.307031		.307031		
40 ANESTHESIOLOGY	.117490		.117490		
41 RADIOLOGY-DIAGNOSTIC	.194236		.194236		
44 LABORATORY	.191216		.191216		
49 RESPIRATORY THERAPY	.301047		.301047		
50 PHYSICAL THERAPY	.602209		.602209		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.754887		.754887		
56 DRUGS CHARGED TO PATIENTS	.397905		.397905		
59 ONCOLOGY	1.459964		1.459964		
OUTPAT SERVICE COST CNTRS					
60 CLINIC	.587690		.587690		
61 EMERGENCY	.625465		.625465		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.518774		1.518774		
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES	.744613		.744613		
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					

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		1,190,808			
40 ANESTHESIOLOGY		254,032			
41 RADIOLOGY-DIAGNOSTIC		3,412,213			
44 LABORATORY		3,602,440			
49 RESPIRATORY THERAPY		685,079			
50 PHYSICAL THERAPY		344,547			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		381,950			
56 DRUGS CHARGED TO PATIENTS		1,122,248			
59 ONCOLOGY		46,868			
OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY		914,191			
62 OBSERVATION BEDS (NON-DISTINCT PART)		696,932			
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES					
101 SUBTOTAL		12,651,308			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		12,651,308			

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM	365,615		
40 ANESTHESIOLOGY	29,846		
41 RADIOLOGY-DIAGNOSTIC	662,775		
44 LABORATORY	688,844		
49 RESPIRATORY THERAPY	206,241		
50 PHYSICAL THERAPY	207,489		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	288,329		
56 DRUGS CHARGED TO PATIENTS	446,548		
59 ONCOLOGY	68,426		
OUTPAT SERVICE COST CNTRS			
60 CLINIC			
61 EMERGENCY	571,794		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1,058,482		
OTHER REIMBURS COST CNTRS			
65 AMBULANCE SERVICES			
101 SUBTOTAL	4,594,389		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104 NET CHARGES	4,594,389		

(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				
		Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1)
Cost Center Description		1	2	3	4	5
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.307031				431,987
40	ANESTHESIOLOGY	.117490				100,895
41	RADIOLOGY-DIAGNOSTIC	.194236				1,260,910
44	LABORATORY	.191216				831,507
49	RESPIRATORY THERAPY	.301047				162,717
50	PHYSICAL THERAPY	.602209				74,525
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.754887				131,852
56	DRUGS CHARGED TO PATIENTS	.397905				262,165
59	ONCDLOGY	1.459964				18,558
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	.587690				4,026
61	EMERGENCY	.625465				832,436
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.518774				
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	.744613				
101	SUBTOTAL					4,111,578
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104	NET CHARGES					4,111,578

TITLE XIX - O/P

HOSPITAL

Cost Center Description	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
(A) ANCILLARY SRVC COST CNTRS	5.01	5.02	5.03	6	7
37 OPERATING ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC					
44 LABORATORY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56 DRUGS CHARGED TO PATIENTS					
59 ONCOLOGY					
60 OUTPAT SERVICE COST CNTRS					
61 CLINIC					
62 EMERGENCY					
62 OBSERVATION BEDS (NON-DISTINCT PART)					
65 OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
104 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		132,633			
40	ANESTHESIOLOGY		11,854			
41	RADIOLOGY-DIAGNOSTIC		244,914			
44	LABORATORY		158,997			
49	RESPIRATORY THERAPY		48,985			
50	PHYSICAL THERAPY		44,880			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		99,533			
56	DRUGS CHARGED TO PATIENTS		104,317			
59	ONCOLOGY		27,094			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC		2,366			
61	EMERGENCY		520,660			
62	OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL		1,396,233			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104	NET CHARGES		1,396,233			

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)	4,279
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,603
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,603
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	643
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	33
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)	1,881
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	643
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	3,858,147
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	2,972
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	586,784
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,271,363

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,156,334
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,156,334
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.036444
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	876.03
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	3,271,363

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 907.95
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,707,854
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,707,854

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
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42	NURSERY (TITLE V & XIX ONLY) INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS				
43	INTENSIVE CARE UNIT	572,344	149	3,841.23	76
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				

1
 1,721,526
 3,721,313

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) 583,812
 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 583,812
 63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE
 COST REPORTING PERIOD
 64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE
 COST REPORTING PERIOD
 65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

TITLE XVIII PART A HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	1,166
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	907.96
85	OBSERVATION BED COST	1,058,681

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)	4,279
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,603
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,603
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	643
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	33
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)	116
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	33
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	2,970
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	2,520
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	-2,520

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,156,334
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,156,334
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.000798
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	876.03
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	-2,520

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 - .70
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST -81
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST -81

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
--	------------------------	------------------------	--------------------------	----------------------	----------------------

42	NURSERY (TITLE V & XIX ONLY)				
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS				
43	INTENSIVE CARE UNIT	149		14	
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				150,564
49	TOTAL PROGRAM INPATIENT COSTS				150,483

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 150,483

TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES 40
 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	2,970
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	2,970

TITLE XIX - I/P HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS		1,166
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	-	.70
85	OBSERVATION BED COST		-816

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2008 I
 I 14-1327 I

TITLE XVIII, PART A HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES	INPATIENT CHARGES	INPATIENT COST
		1	2	3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		1,570,933	
26	INTENSIVE CARE UNIT		101,960	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.307031	480,928	147,660
40	ANESTHESIOLOGY	.117490	16,757	1,969
41	RADIOLOGY-DIAGNOSTIC	.194236	407,578	79,166
44	LABORATORY	.191216	551,338	105,425
49	RESPIRATORY THERAPY	.301047	313,844	94,482
50	PHYSICAL THERAPY	.602209	115,281	69,423
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.754887	1,163,876	878,595
56	DRUGS CHARGED TO PATIENTS	.397905	866,553	344,806
59	ONCOLOGY	1.459964		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.587690		
61	EMERGENCY	.625465		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.518774		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		3,916,155	1,721,526
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		3,916,155	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2008 I
 I 14-2327 I

TITLE XVIII, PART A SWING BED SNF

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.307031		
40	ANESTHESIOLOGY	.117490		
41	RADIOLOGY-DIAGNOSTIC	.194236	30,801	5,983
44	LABORATORY	.191216	62,717	11,992
49	RESPIRATORY THERAPY	.301047	79,122	23,819
50	PHYSICAL THERAPY	.602209	101,670	61,227
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.754887	91,282	68,908
56	DRUGS CHARGED TO PATIENTS	.397905	239,069	95,127
59	ONCOLOGY	1.459964		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.587690		
61	EMERGENCY	.625465		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.518774		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		604,661	267,056
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		604,661	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

TITLE XIX HOSPITAL OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES	INPATIENT CHARGES	INPATIENT COST
		1	2	3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		195,941	
26	INTENSIVE CARE UNIT		4,046	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.307031	59,591	18,296
40	ANESTHESIOLOGY	.117490	18,948	2,226
41	RADIOLOGY-DIAGNOSTIC	.194236	21,598	4,195
44	LABORATORY	.191216	34,606	6,617
49	RESPIRATORY THERAPY	.301047	33,105	9,966
50	PHYSICAL THERAPY	.602209	7,844	4,724
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.754887	97,351	73,489
56	DRUGS CHARGED TO PATIENTS	.397905	56,643	22,539
59	ONCOLOGY	1.459964		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.587690		
61	EMERGENCY	.625465	13,609	8,512
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.518774		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		343,295	150,564
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		343,295	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/21/2009
I	14-1327	I	FROM 1/ 1/2008	I	WORKSHEET E	
I	COMPONENT NO:	I	TO 12/31/2008	I	PART B	
I	14-1327	I		I		

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	4,594,389
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	4,594,389
	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)	4,640,333
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	CAH DEDUCTIBLES	43,109
18.01	CAH ACTUAL BILLED COINSURANCE	1,820,194
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	2,777,030
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	2,777,030
24	PRIMARY PAYER PAYMENTS	711
25	SUBTOTAL	2,776,319
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	131,948
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	131,948
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
28	SUBTOTAL	2,908,267
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	2,908,267
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	2,596,422
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	311,845
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2008 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		3,138,757		2,515,888
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		134,082
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	4/12/2008	87,021		
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50			4/12/2008	53,548
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		87,021		-53,548
4 TOTAL INTERIM PAYMENTS		3,225,778		2,596,422
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)		182,964		311,845
7 TOTAL MEDICARE PROGRAM LIABILITY		3,408,742		2,908,267

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2008 I
 I 14-2327 I I

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		875,881		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01				
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50	4/12/2008	47,231		
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		-47,231		NONE
4 TOTAL INTERIM PAYMENTS		828,650		
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	18,311	
AMOUNT (BALANCE DUE)	SETTLEMENT TO PROGRAM	.02		
BASED ON COST REPORT (1)				
7 TOTAL MEDICARE PROGRAM LIABILITY			846,961	

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

I PROVIDER NO: I PERIOD: I PREPARED 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I
 I COMPONENT NO: I TO 12/31/2008 I WORKSHEET E-2
 I 14-2327 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)	589,650	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	269,727	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	643	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	859,377	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	859,377	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	859,377	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	12,416	
14	80% OF PART B COSTS		
15	SUBTOTAL	846,961	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	846,961	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	828,650	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	18,311	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I WORKSHEET E-3
 I COMPONENT NO: I TO 12/31/2008 I PART II
 I 14-1327 I I

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	3,721,313
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	3,721,313
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	3,758,526
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	3,758,526
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	384,000
21	EXCESS REASONABLE COST	
22	SUBTOTAL	3,374,526
23	COINSURANCE	3,584
24	SUBTOTAL	3,370,942
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	37,800
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	37,800
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
26	SUBTOTAL	3,408,742
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	3,408,742
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	3,225,778
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	182,964
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I
 I I TO 12/31/2008 I WORKSHEET G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	1,175,010			
2 TEMPORARY INVESTMENTS	2,417,285			
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	8,768,454			
5 OTHER RECEIVABLES	250,807			
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-4,259,987			
7 INVENTORY	486,215			
8 PREPAID EXPENSES				
9 OTHER CURRENT ASSETS	491,852			
10 DUE FROM OTHER FUNDS				
11 TOTAL CURRENT ASSETS	9,329,636			
FIXED ASSETS				
12 LAND				
12.01 LAND IMPROVEMENTS				
13.01 LESS ACCUMULATED DEPRECIATION				
14 BUILDINGS	23,018,963			
14.01 LESS ACCUMULATED DEPRECIATION	-13,935,311			
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	9,083,652			
OTHER ASSETS				
22 INVESTMENTS				
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS	775,379			
26 TOTAL OTHER ASSETS	775,379			
27 TOTAL ASSETS	19,188,667			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	549,112			
29 SALARIES, WAGES & FEES PAYABLE	991,893			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	187,272			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS	886,900			
35 OTHER CURRENT LIABILITIES				
36 TOTAL CURRENT LIABILITIES	2,615,177			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE	6,240,000			
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	6,240,000			
43 TOTAL LIABILITIES	8,855,177			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	10,333,490			
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	10,333,490			
52 TOTAL LIABILITIES AND FUND BALANCES	19,188,667			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		8,011,476		
2 NET INCOME (LOSS)		2,325,693		
3 TOTAL		10,337,169		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADDITIONS (CREDIT ADJUSTM				
6				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL		10,337,169		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM		3,679		
14				
15				
16				
17				
18 TOTAL DEDUCTIONS		3,679		
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		10,333,490		

	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 5/21/2009
 I 14-1327 I FROM 1/ 1/2008 I WORKSHEET G-2
 I I TO 12/31/2008 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	3,156,334		3,156,334
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	3,156,334		3,156,334
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT	130,028		130,028
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	130,028		130,028
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	3,286,362		3,286,362
17 00 ANCILLARY SERVICES	8,301,779	27,554,485	35,856,264
18 00 OUTPATIENT SERVICES			
20 00 AMBULANCE SERVICES		1,240,303	1,240,303
24 00	37,304	2,621,045	2,658,349
25 00 TOTAL PATIENT REVENUES	11,625,445	31,415,833	43,041,278

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		23,016,097	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)	2,831,543		
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS		2,831,543	
40 00 TOTAL OPERATING EXPENSES		20,184,554	

STATEMENT OF REVENUES AND EXPENSES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/21/2009
I	14-1327	I	FROM 1/ 1/2008	I	WORKSHEET	G-3
I		I	TO 12/31/2008	I		

DESCRIPTION

1	TOTAL PATIENT REVENUES	43,041,278
2	LESS: ALLOWANCES AND DISCOUNTS ON	21,306,548
3	NET PATIENT REVENUES	21,734,730
4	LESS: TOTAL OPERATING EXPENSES	20,184,554
5	NET INCOME FROM SERVICE TO PATIENT	1,550,176
	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 (SPECIFY)	533,999
24.01		241,518
25	TOTAL OTHER INCOME	775,517
26	TOTAL	2,325,693
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIO	2,325,693