IN LIEU OF FORM CMS-2552-96(04/2005)
PREPARED 4/10/2009 9:41

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 COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 15-4041	PERIOD FROM 1/ 1/2008 TO 12/31/2008	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 4/10/2009 TIME 9:41

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 IMPRISIONMENT 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:
BHC MEADOWS HOSPITAL 15-4041
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: 4/10/2009 TIME 9:41

w.T9T:c:yfPclReqtajb8lNlJe5ml0
1tOFOOoStZvF4C93ndNRBJOoUJ1nKg
bjIKOYRjNbOFCoOJ

PI ENCRYPTION INFORMATION
DATE: 4/10/2009 TIME 9:41

ncgl0:1SmloaebTSGm3j1rT4E3XDm0
Ip1FV0WyPm6nxPSGDUQJcKJbNF81yv
ULe:3Czw1k00Qpli

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	-39,885	6,765	0	106,401
100	TOTAL	-39,885	6,765	0	106,401

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: 15-4041 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 4/10/2009 I WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 3600 NORTH PROW ROAD P.O. BOX:

1.01 CITY: BLOOMINGTON STATE: IN ZIP CODE: 47404- COUNTY: MONROE

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

	COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX
	0	1	2	2.01	3	4	5	6
02.00	HOSPITAL	BHC MEADOWS HOSPITAL	15-4041		8/ 5/1992	O	P	O

17	COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2008 TO: 12/31/2008			
		1	2	
18	TYPE OF CONTROL	4		
	TYPE OF HOSPITAL/SUBPROVIDER			
19	HOSPITAL	4		
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.	1		
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 RECLASSICATION 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.	1	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	1		
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	1		
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 TERMINATION IN COL. 3.			/ /
24.01	IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COLUMN 3.			/ /
25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R?	N		
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	N		
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.			
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	N		
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	N	N	

25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)	N	N				
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH),ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0					
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /						
26.02	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /						
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	N	/ /				
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02						
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	1 0	2 0.0000	3 0.0000	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	0.00	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	0.00%	
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)	N					
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70						
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)						
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).						
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II						
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N					
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N					
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N					
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N					
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N					
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N					

MISCELLANEOUS COST REPORT INFORMATION

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

		V	XVIII	XIX
	PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL	1	2	3
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	Y
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?	Y
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	Y	
40.01	NAME: FI/CONTRACTOR NAME		FI/CONTRACTOR #
40.02	STREET: P.O. BOX:		
40.03	CITY: STATE: ZIP CODE: -		
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY?	N	
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.	N	00/00/0000
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?		
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?		
45.03	WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?		
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).		

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

		PART A 1	PART B 2	OUTPATIENT ASC 3	OUTPATIENT RADIOLOGY 4	OUTPATIENT DIAGNOSTIC 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	

		DATE 0	Y OR N 1	LIMIT 2	Y OR N 3	FEES 4
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		N	0.00		0
56.01	ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02	THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03	FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0

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

60.01 IF LINE 60 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

MULTICAMPUS

61.00 DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER "Y" FOR YES AND "N" FOR NO.

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL1. 1, STATE IN COL.2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00						0.00
62.01						0.00
62.02						0.00
62.03						0.00
62.04						0.00
62.05						0.00
62.06						0.00
62.07						0.00
62.08						0.00
62.09						0.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

I PROVIDER NO: 15-4041 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 4/10/2009 I WORKSHEET S-3 I PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	I/P DAYS / O/P VISITS / TRIPS CAH N/A 2.01	TITLE V 3	TITLE XVIII 4	NOT LTCH N/A 4.01	TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	38	13,482		522	401		826
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	38	13,482		522	401		826
6	INTENSIVE CARE UNIT							
7	CORONARY CARE UNIT							
8	BURN INTENSIVE CARE UNIT							
9	SURGICAL INTENSIVE CARE UNIT							
11	NURSERY							
12	TOTAL	38	13,482		522	401		826
13	RPCH VISITS							
17	OTHER LONG TERM CARE	30	10,980					
25	TOTAL	68						
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							

	COMPONENT	I/P DAYS / O/P VISITS / TRIPS TITLE XIX ADMITTED 5.01	OBSERVATION BEDS NOT ADMITTED 5.02	TOTAL ALL PATS 6	TOTAL OBSERVATION BEDS ADMITTED 6.01	NOT ADMITTED 6.02	-- INTERNS & RES. FTES -- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			6,717				
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS			6,717				
6	INTENSIVE CARE UNIT							
7	CORONARY CARE UNIT							
8	BURN INTENSIVE CARE UNIT							
9	SURGICAL INTENSIVE CARE UNIT							
11	NURSERY							
12	TOTAL			6,717				
13	RPCH VISITS							
17	OTHER LONG TERM CARE			10,089				
25	TOTAL							
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							

	COMPONENT	I & R FTES NET 9	--- FULL TIME EQUIV --- EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	DISCHARGES TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS				70	51	105	1,047
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
6	INTENSIVE CARE UNIT							
7	CORONARY CARE UNIT							
8	BURN INTENSIVE CARE UNIT							
9	SURGICAL INTENSIVE CARE UNIT							
11	NURSERY							
12	TOTAL		76.33		70	51	105	1,047
13	RPCH VISITS							
17	OTHER LONG TERM CARE		31.54					76
25	TOTAL		107.87					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							

Health Financial Systems MCRIF32 FOR BHC MEADOWS HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

I PROVIDER NO: I PERIOD: I PREPARED 4/10/2009

I 15-4041 I FROM 1/ 1/2008 I WORKSHEET A

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES I TO 12/31/2008 I

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		258,344	258,344		258,344
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		9,369	9,369	41,329	50,698
5	0500	EMPLOYEE BENEFITS	43,689	469,525	513,214		513,214
6	0600	ADMINISTRATIVE & GENERAL	1,591,685	1,300,628	2,892,313	-117,624	2,774,689
7	0700	MAINTENANCE & REPAIRS	71,570	182,943	254,513	-1,137	253,376
9	0900	LAUNDRY & LINEN SERVICE		30,601	30,601		30,601
10	1000	HOUSEKEEPING	47,644	16,471	64,115		64,115
11	1100	DIETARY	137,597	161,250	298,847		298,847
12	1200	CAFETERIA					
14	1400	NURSING ADMINISTRATION	216,164	20,293	236,457		236,457
14.01	1401	MEDICAL ADMINISTRATION	521,300	267,004	788,304		788,304
17	1700	MEDICAL RECORDS & LIBRARY	59,605	52,679	112,284		112,284
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	1,478,564	164,419	1,642,983	-115,359	1,527,624
26	2600	INTENSIVE CARE UNIT					
27	2700	CORONARY CARE UNIT					
28	2800	BURN INTENSIVE CARE UNIT					
29	2900	SURGICAL INTENSIVE CARE UNIT					
33	3300	NURSERY					
36	3600	OTHER LONG TERM CARE	1,006,562	124,555	1,131,117	97,743	1,228,860
		ANCILLARY SRVC COST CNTRS					
44	4400	LABORATORY		31,892	31,892		31,892
56	5600	DRUGS CHARGED TO PATIENTS		176,442	176,442	-3,867	172,575
59	3550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		53,900	53,900		53,900
		OUTPAT SERVICE COST CNTRS					
60	6000	CLINIC					
61	6100	EMERGENCY					
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
		SPEC PURPOSE COST CENTERS					
90	9000	OTHER CAPITAL RELATED COSTS					
95		SUBTOTALS	5,174,380	3,320,315	8,494,695	-98,915	8,395,780
		NONREIMBURS COST CENTERS					
100.01	7951	COMMUNITY RELATIONS				98,915	98,915
100.02	7952	OUTPATIENT MEALS					
100.03	7953	CLINICAL TRIALS					
101		TOTAL	5,174,380	3,320,315	8,494,695	-0-	8,494,695

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 15-4041 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 4/10/2009 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	-6,694	251,650
4	0400	NEW CAP REL COSTS-MVBLE EQUIP	43,972	94,670
5	0500	EMPLOYEE BENEFITS	-93,235	419,979
6	0600	ADMINISTRATIVE & GENERAL	-233,066	2,541,623
7	0700	MAINTENANCE & REPAIRS	-1,774	251,602
9	0900	LAUNDRY & LINEN SERVICE		30,601
10	1000	HOUSEKEEPING		64,115
11	1100	DIETARY	-12,712	286,135
12	1200	CAFETERIA		
14	1400	NURSING ADMINISTRATION		236,457
14.01	1401	MEDICAL ADMINISTRATION	-788,303	1
17	1700	MEDICAL RECORDS & LIBRARY	-3,618	108,666
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS	-20,560	1,507,064
26	2600	INTENSIVE CARE UNIT		
27	2700	CORONARY CARE UNIT		
28	2800	BURN INTENSIVE CARE UNIT		
29	2900	SURGICAL INTENSIVE CARE UNIT		
33	3300	NURSERY		
36	3600	OTHER LONG TERM CARE	-4,677	1,224,183
		ANCILLARY SRVC COST CNTRS		
44	4400	LABORATORY		31,892
56	5600	DRUGS CHARGED TO PATIENTS		172,575
59	3550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		53,900
		OUTPAT SERVICE COST CNTRS		
60	6000	CLINIC		
61	6100	EMERGENCY		
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
		SPEC PURPOSE COST CENTERS		
90	9000	OTHER CAPITAL RELATED COSTS		-0-
95		SUBTOTALS	-1,120,667	7,275,113
		NONREIMBURS COST CENTERS		
100.01	7951	COMMUNITY RELATIONS		98,915
100.02	7952	OUTPATIENT MEALS		
100.03	7953	CLINICAL TRIALS		
101		TOTAL	-1,120,667	7,374,028

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 4/10/2009
I 15-4041 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	
7	MAINTENANCE & REPAIRS	0700	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
14.01	MEDICAL ADMINISTRATION	1401	NURSING ADMINISTRATION
17	MEDICAL RECORDS & LIBRARY	1700	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
27	CORONARY CARE UNIT	2700	
28	BURN INTENSIVE CARE UNIT	2800	
29	SURGICAL INTENSIVE CARE UNIT	2900	
33	NURSERY	3300	
36	OTHER LONG TERM CARE	3600	
	ANCILLARY SRVC COST		
44	LABORATORY	4400	
56	DRUGS CHARGED TO PATIENTS	5600	
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	SPEC PURPOSE COST CE		
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
100.01	COMMUNITY RELATIONS	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	OUTPATIENT MEALS	7952	OTHER NONREIMBURSABLE COST CENTERS
100.03	CLINICAL TRIALS	7953	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

Health Financial Systems MCRIF32 FOR BHC MEADOWS HOSPITAL

IN LIEU OF FORM CMS-2552-96 (09/1996)

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED 4/10/2009
154041	FROM 1/ 1/2008	WORKSHEET A-6
	TO 12/31/2008	

	EXPLANATION OF RECLASSIFICATION	CODE (1) 1	COST CENTER 2	INCREASE LINE NO 3	SALARY 4	OTHER 5
1	COMMUNITY RELATIONS	A	COMMUNITY RELATIONS	100.01	73,984	24,931
2	LEASE/RENT	B	NEW CAP REL COSTS-MVBLE EQUIP	4		41,329
3						
4						
5	ACTIVITY THERAPY RECLASS	E	OTHER LONG TERM CARE	36	62,458	6,649
6	PHARMACY RECLASS	F	OTHER LONG TERM CARE	36		3,867
7	DIRECTOR OF CLINICAL SERVICES	G	OTHER LONG TERM CARE	36	35,100	2,743
8			ADMINISTRATIVE & GENERAL	6	7,800	609
36	TOTAL RECLASSIFICATIONS				179,342	80,128

(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.

	EXPLANATION OF RECLASSIFICATION	DECREASE CODE (1)	COST CENTER	LINE NO	SALARY	OTHER	A-7 REF
		1	6	7	8	9	10
1	COMMUNITY RELATIONS	A	ADMINISTRATIVE & GENERAL	6	73,984	24,931	
2	LEASE/RENT	B	ADMINISTRATIVE & GENERAL	6		27,118	10
3			MAINTENANCE & REPAIRS	7		1,137	
4			OTHER LONG TERM CARE	36		13,074	
5	ACTIVITY THERAPY RECLASS	E	ADULTS & PEDIATRICS	25	62,458	6,649	
6	PHARMACY RECLASS	F	DRUGS CHARGED TO PATIENTS	56		3,867	
7	DIRECTOR OF CLINICAL SERVICES	G	ADULTS & PEDIATRICS	25	42,900	3,352	
8							
36	TOTAL RECLASSIFICATIONS				179,342	80,128	

(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 : COMMUNITY RELATIONS

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	COMMUNITY RELATIONS	100.01	98,915	ADMINISTRATIVE & GENERAL	6	98,915
TOTAL RECLASSIFICATIONS FOR CODE A			98,915			98,915

RECLASS CODE: B
EXPLANATION : LEASE/RENT

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	41,329	ADMINISTRATIVE & GENERAL	6	27,118
2.00			0	MAINTENANCE & REPAIRS	7	1,137
5.00			0	OTHER LONG TERM CARE	36	13,074
TOTAL RECLASSIFICATIONS FOR CODE B			41,329			41,329

RECLASS CODE: E
EXPLANATION : ACTIVITY THERAPY RECLASS

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OTHER LONG TERM CARE	36	69,107	ADULTS & PEDIATRICS	25	69,107
TOTAL RECLASSIFICATIONS FOR CODE E			69,107			69,107

RECLASS CODE: F
EXPLANATION : PHARMACY RECLASS

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OTHER LONG TERM CARE	36	3,867	DRUGS CHARGED TO PATIENTS	56	3,867
TOTAL RECLASSIFICATIONS FOR CODE F			3,867			3,867

RECLASS CODE: G
EXPLANATION : DIRECTOR OF CLINICAL SERVICES

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OTHER LONG TERM CARE	36	37,843	ADULTS & PEDIATRICS	25	46,252
2.00	ADMINISTRATIVE & GENERAL	6	8,409			0
TOTAL RECLASSIFICATIONS FOR CODE G			46,252			46,252

Health Financial Systems MCRIF32 FOR BHC MEADOWS HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1996)

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS

PROVIDER NO: 15-4041

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

PREPARED 4/10/2009

WORKSHEET A-7

PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS 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	ACQUISITIONS PURCHASES 2	ACQUISITIONS DONATION 3	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1	LAND	463,972					463,972	
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE	3,516,755					3,516,755	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	526,052					526,052	
7	SUBTOTAL	4,506,779					4,506,779	
8	RECONCILING ITEMS							
9	TOTAL	4,506,779					4,506,779	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS	CAPITLIZED GROSS ASSETS LEASES	FOR RATIO	RATIO	ALLOCATION OF OTHER CAPITAL INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	TOTAL
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL								
4	NEW CAP REL COSTS-MV								
5	TOTAL				1.000000				

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	187,947		4,710	3,246	55,747		251,650
4	NEW CAP REL COSTS-MV	48,925	41,329		4,416			94,670
5	TOTAL	236,872	41,329	4,710	7,662	55,747		346,320

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

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	194,641		4,710	3,246	55,747		258,344
4	NEW CAP REL COSTS-MV	4,953			4,416			9,369
5	TOTAL	199,594		4,710	7,662	55,747		267,713

---

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

ADJUSTMENTS TO EXPENSES

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST. A-7 REF. 5
1	INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5	INVESTMENT INCOME-OTHER					
6	TRADE, QUANTITY AND TIME DISCOUNTS					
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES					
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-614,978			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1	-133,950			
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS	B	-12,712	DIETARY	11	
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-3,618	MEDICAL RECORDS & LIBRARY	17	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES	B	-845	ADMINISTRATIVE & GENERAL	6	
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		**COST CENTER DELETED**	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		**COST CENTER DELETED**	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	A	-6,694	NEW CAP REL COSTS-BLDG &	3	9
32	DEPRECIATION-NEW MOVABLE EQUIP	A	43,972	NEW CAP REL COSTS-MVBLE E	4	9
33	NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	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	MISCELLANEOUS INCOME	B	-8,800	ADMINISTRATIVE & GENERAL	6	
38	PATIENT TRANSPORTATION	A	-671	ADMINISTRATIVE & GENERAL	6	
39	PATIENT TRANSPORTATION	A	-13,658	ADULTS & PEDIATRICS	25	
39.01	PATIENT TRANSPORTATION	A	-659	OTHER LONG TERM CARE	36	
40						
41						
42						
43						
44						
45	OTHER MEDICAL STAFF EXPENSE	A	-183,793	MEDICAL ADMINISTRATION	14.01	
46	WORKERS COMP INS ADJUSTMENT	A	-22,213	EMPLOYEE BENEFITS	5	
47	MEDICAL INS ADJUSTMENT	A	-61,522	EMPLOYEE BENEFITS	5	
48	LIABILITY INS ADJUSTMENT	A	-41,409	ADMINISTRATIVE & GENERAL	6	
49	MISCELLANEOUS	A	-9,500	EMPLOYEE BENEFITS	5	
49.01	MISCELLANEOUS	A	-1,774	MAINTENANCE & REPAIRS	7	
49.06	NONALLOWABLE COMMUNITY RELATIONS EXP	A	-23,321	ADMINISTRATIVE & GENERAL	6	
49.07	MISCELLANEOUS	A	-24,070	ADMINISTRATIVE & GENERAL	6	
49.08	MISCELLANEOUS	A	-452	ADULTS & PEDIATRICS	25	
49.09						
50	TOTAL (SUM OF LINES 1 THRU 49)		-1,120,667			

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

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

LINE NO.		COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUST-MENTS	WKSHT A-7 COL. REF.
1	6	ADMINISTRATIVE & GENERAL	INTERCOMPANY INTEREST				
2	6	ADMINISTRATIVE & GENERAL	HOME OFFICE COSTS	223,249	357,199	-133,950	
3							
4							
4.03	5	EMPLOYEE BENEFITS	HUMAN RESOURCES	1,376	1,376		
4.04	6	ADMINISTRATIVE & GENERAL	ADMINISTRATION	21,928	21,928		
4.06	7	MAINTENANCE & REPAIRS	MAINTENANCE	341	341		
4.08	17	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	5,742	5,742		
4.10	36	OTHER LONG TERM CARE	RTC				
5		TOTALS		252,636	386,586	-133,950	
		1	2	3	4	5	6

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

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

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

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
	1	2	3	4	5	6
1	B		100.00	PSI	0.00	HOSPITAL MGMT
2	B		0.00	COLUMBUS	0.00	PSI HOSPITAL
3	B		0.00	PINNACLE POINTE	0.00	PSI HOSPITAL
4	B		0.00	VALLE VISTA	0.00	PSI HOSPITAL
5			0.00		0.00	

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

Health Financial Systems MCRIF32 FOR BHC MEADOWS HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 4/10/2009
I 15-4041 I FROM 1/ 1/2008 I WORKSHEET A-8-2
I I TO 12/31/2008 I GROUP 1

	WKSHT A LINE NO. 1		COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN-ERATION 3	PROFES-SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	14	1 AGGREGATE		604,510	604,510					
2	25	AGGREGATE		6,450	6,450					
3	36	AGGREGATE		7,500		7,500	154,100	47	3,482	174
4		0								
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		618,460	610,960	7,500		47	3,482	174

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 15-4041 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 4/10/2009 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 10		COST CENTER/ PHYSICIAN IDENTIFIER 11	COST OF MEMBERSHIPS & CONTINUING EDUCATION 12	PROVIDER COMPONENT SHARE OF COL 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COL 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUSTMENT 18
1	14	1 AGGREGATE								604,510
2	25	AGGREGATE								6,450
3	36	AGGREGATE						3,482	4,018	4,018
4		0								
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						3,482	4,018	614,978

Health Financial Systems MCRIF32 FOR BHC MEADOWS HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1997)

COST ALLOCATION STATISTICS

I PROVIDER NO: 15-4041 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 4/10/2009 I NOT A CMS WORKSHEET

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE FOO TAGE	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE FOO TAGE	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM. COST	ENTERED
7	MAINTENANCE & REPAIRS	3	SQUARE FOO TAGE	ENTERED
9	LAUNDRY & LINEN SERVICE	8	DIRECT COS T	ENTERED
10	HOUSEKEEPING	3	SQUARE FOO TAGE	ENTERED
11	DIETARY	10	MEALS SERV ED	ENTERED
12	CAFETERIA	11	FTES	ENTERED
14	NURSING ADMINISTRATION	13	NURSING AD MIN H	ENTERED
14.01	MEDICAL ADMINISTRATION	14	MEDICAL AD MIN T	ENTERED
17	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	ENTERED

		COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	EMPLOYEE BENEFITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS
			0	3	4	5	5a.00	6	7
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &	251,650	251,650					
004		NEW CAP REL COSTS-MVBLE E	94,670		94,670				
005		EMPLOYEE BENEFITS	419,979	1,499	564	422,042			
006		ADMINISTRATIVE & GENERAL	2,541,623	38,685	14,553	125,487	2,720,348	2,720,348	
007		MAINTENANCE & REPAIRS	251,602	6,747	2,538	5,887	266,774	155,945	422,719
009		LAUNDRY & LINEN SERVICE	30,601	5,473	2,059		38,133	22,291	11,300
010		HOUSEKEEPING	64,115	5,539	2,084	3,919	75,657	44,226	11,437
011		DIETARY	286,135	23,495	8,839	11,318	329,787	192,780	48,514
012		CAFETERIA							
014		NURSING ADMINISTRATION	236,457	1,505	566	17,781	256,309	149,827	3,108
014	01	MEDICAL ADMINISTRATION	1	4,126	1,552	42,881	48,560	28,386	8,520
017		MEDICAL RECORDS & LIBRARY	108,666	3,466	1,304	4,903	118,339	69,176	7,156
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	1,507,064	78,677	29,598	112,957	1,728,296	1,010,292	162,457
026		INTENSIVE CARE UNIT							
027		CORONARY CARE UNIT							
028		BURN INTENSIVE CARE UNIT							
029		SURGICAL INTENSIVE CARE U							
033		NURSERY							
036		OTHER LONG TERM CARE	1,224,183	81,685	30,730	90,823	1,427,421	834,410	168,673
		ANCILLARY SRVC COST CNTRS							
044		LABORATORY	31,892	489	184		32,565	19,036	1,009
056		DRUGS CHARGED TO PATIENTS	172,575				172,575	100,880	
059		PSYCHIATRIC/PSYCHOLOGICAL	53,900				53,900	31,508	
		OUTPAT SERVICE COST CNTRS							
060		CLINIC							
061		EMERGENCY							
062		OBSERVATION BEDS (NON-DIS							
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	7,275,113	251,386	94,571	415,956	7,268,664	2,658,757	422,174
		NONREIMBURS COST CENTERS							
100	01	COMMUNITY RELATIONS	98,915	264	99	6,086	105,364	61,591	545
100	02	OUTPATIENT MEALS							
100	03	CLINICAL TRIALS							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	7,374,028	251,650	94,670	422,042	7,374,028	2,720,348	422,719

		COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL ADMIN ISTRATION	MEDICAL RECOR DS & LIBRARY
			9	10	11	12	14	14.01	17
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL							
007		MAINTENANCE & REPAIRS							
009		LAUNDRY & LINEN SERVICE	71,724						
010		HOUSEKEEPING		131,320					
011		DIETARY		15,928	587,009				
012		CAFETERIA			61,338	61,338			
014		NURSING ADMINISTRATION		1,020		2,697	412,961		
014	01	MEDICAL ADMINISTRATION		2,797				88,263	
017		MEDICAL RECORDS & LIBRARY		2,350		2,245			199,266
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	28,667	53,337	210,100	27,107	203,189	88,263	134,263
026		INTENSIVE CARE UNIT							
027		CORONARY CARE UNIT							
028		BURN INTENSIVE CARE UNIT							
029		SURGICAL INTENSIVE CARE U							
033		NURSERY							
036		OTHER LONG TERM CARE	43,057	55,378	315,571	27,985	209,772		59,048
		ANCILLARY SRVC COST CNTRS							
044		LABORATORY		331					1,462
056		DRUGS CHARGED TO PATIENTS							3,088
059		PSYCHIATRIC/PSYCHOLOGICAL							1,401
		OUTPAT SERVICE COST CNTRS							
060		CLINIC							4
061		EMERGENCY							
062		OBSERVATION BEDS (NON-DIS							
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	71,724	131,141	587,009	60,034	412,961	88,263	199,266
		NONREIMBURS COST CENTERS							
100	01	COMMUNITY RELATIONS		179		1,304			
100	02	OUTPATIENT MEALS							
100	03	CLINICAL TRIALS							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	71,724	131,320	587,009	61,338	412,961	88,263	199,266

		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			
007		MAINTENANCE & REPAIRS			
009		LAUNDRY & LINEN SERVICE			
010		HOUSEKEEPING			
011		DIETARY			
012		CAFETERIA			
014		NURSING ADMINISTRATION			
014	01	MEDICAL ADMINISTRATION			
017		MEDICAL RECORDS & LIBRARY			
		INPAT ROUTINE SRVC CNTRS			
025		ADULTS & PEDIATRICS	3,645,971		3,645,971
026		INTENSIVE CARE UNIT			
027		CORONARY CARE UNIT			
028		BURN INTENSIVE CARE UNIT			
029		SURGICAL INTENSIVE CARE U			
033		NURSERY			
036		OTHER LONG TERM CARE	3,141,315		3,141,315
		ANCILLARY SRVC COST CNTRS			
044		LABORATORY	54,403		54,403
056		DRUGS CHARGED TO PATIENTS	276,543		276,543
059		PSYCHIATRIC/PSYCHOLOGICAL	86,809		86,809
		OUTPAT SERVICE COST CNTRS			
060		CLINIC	4		4
061		EMERGENCY			
062		OBSERVATION BEDS (NON-DIS			
		SPEC PURPOSE COST CENTERS			
095		SUBTOTALS	7,205,045		7,205,045
		NONREIMBURS COST CENTERS			
100	01	COMMUNITY RELATIONS	168,983		168,983
100	02	OUTPATIENT MEALS			
100	03	CLINICAL TRIALS			
101		CROSS FOOT ADJUSTMENT			
102		NEGATIVE COST CENTER			
103		TOTAL	7,374,028		7,374,028

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: 15-4041 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 4/10/2009 I WORKSHEET B PART III

		COST CENTER DESCRIPTION	DIR ASSGNED NEW CAPITAL REL COSTS	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
			0	3	4	4a	5	6	7
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS		1,499	564	2,063	2,063		
006		ADMINISTRATIVE & GENERAL	27,556	38,685	14,553	80,794	613	81,407	
007		MAINTENANCE & REPAIRS		6,747	2,538	9,285	29	4,667	13,981
009		LAUNDRY & LINEN SERVICE		5,473	2,059	7,532		667	374
010		HOUSEKEEPING		5,539	2,084	7,623	19	1,323	378
011		DIETARY		23,495	8,839	32,334	55	5,769	1,605
012		CAFETERIA							
014		NURSING ADMINISTRATION		1,505	566	2,071	87	4,484	103
014	01	MEDICAL ADMINISTRATION		4,126	1,552	5,678	210	849	282
017		MEDICAL RECORDS & LIBRARY		3,466	1,304	4,770	24	2,070	237
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS		78,677	29,598	108,275	552	30,233	5,373
026		INTENSIVE CARE UNIT							
027		CORONARY CARE UNIT							
028		BURN INTENSIVE CARE UNIT							
029		SURGICAL INTENSIVE CARE U							
033		NURSERY							
036		OTHER LONG TERM CARE		81,685	30,730	112,415	444	24,970	5,578
		ANCILLARY SRVC COST CNTRS							
044		LABORATORY		489	184	673		570	33
056		DRUGS CHARGED TO PATIENTS						3,019	
059		PSYCHIATRIC/PSYCHOLOGICAL						943	
		OUTPAT SERVICE COST CNTRS							
060		CLINIC							
061		EMERGENCY							
062		OBSERVATION BEDS (NON-DIS							
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	27,556	251,386	94,571	373,513	2,033	79,564	13,963
		NONREIMBURS COST CENTERS							
100	01	COMMUNITY RELATIONS		264	99	363	30	1,843	18
100	02	OUTPATIENT MEALS							
100	03	CLINICAL TRIALS							
101		CROSS FOOT ADJUSTMENTS							
102		NEGATIVE COST CENTER							
103		TOTAL	27,556	251,650	94,670	373,876	2,063	81,407	13,981

		COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL ADMIN ISTRATION	MEDICAL RECOR DS & LIBRARY
			9	10	11	12	14	14.01	17
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL							
007		MAINTENANCE & REPAIRS							
009		LAUNDRY & LINEN SERVICE	8,573						
010		HOUSEKEEPING		9,343					
011		DIETARY		1,133	40,896				
012		CAFETERIA			4,273	4,273			
014		NURSING ADMINISTRATION		73		188	7,006		
014	01	MEDICAL ADMINISTRATION		199				7,218	
017		MEDICAL RECORDS & LIBRARY		167		156			7,424
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	3,426	3,795	14,637	1,888	3,447	7,218	5,005
026		INTENSIVE CARE UNIT							
027		CORONARY CARE UNIT							
028		BURN INTENSIVE CARE UNIT							
029		SURGICAL INTENSIVE CARE U							
033		NURSERY							
036		OTHER LONG TERM CARE	5,147	3,939	21,986	1,950	3,559		2,198
		ANCILLARY SRVC COST CNTRS							
044		LABORATORY		24					54
056		DRUGS CHARGED TO PATIENTS							115
059		PSYCHIATRIC/PSYCHOLOGICAL							52
		OUTPAT SERVICE COST CNTRS							
060		CLINIC							
061		EMERGENCY							
062		OBSERVATION BEDS (NON-DIS							
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	8,573	9,330	40,896	4,182	7,006	7,218	7,424
		NONREIMBURS COST CENTERS							
100	01	COMMUNITY RELATIONS		13		91			
100	02	OUTPATIENT MEALS							
100	03	CLINICAL TRIALS							
101		CROSS FOOT ADJUSTMENTS							
102		NEGATIVE COST CENTER							
103		TOTAL	8,573	9,343	40,896	4,273	7,006	7,218	7,424

		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			
007		MAINTENANCE & REPAIRS			
009		LAUNDRY & LINEN SERVICE			
010		HOUSEKEEPING			
011		DIETARY			
012		CAFETERIA			
014		NURSING ADMINISTRATION			
014	01	MEDICAL ADMINISTRATION			
017		MEDICAL RECORDS & LIBRARY			
		INPAT ROUTINE SRVC CNTRS			
025		ADULTS & PEDIATRICS	183,849		183,849
026		INTENSIVE CARE UNIT			
027		CORONARY CARE UNIT			
028		BURN INTENSIVE CARE UNIT			
029		SURGICAL INTENSIVE CARE U			
033		NURSERY			
036		OTHER LONG TERM CARE	182,186		182,186
		ANCILLARY SRVC COST CNTRS			
044		LABORATORY	1,354		1,354
056		DRUGS CHARGED TO PATIENTS	3,134		3,134
059		PSYCHIATRIC/PSYCHOLOGICAL	995		995
		OUTPAT SERVICE COST CNTRS			
060		CLINIC			
061		EMERGENCY			
062		OBSERVATION BEDS (NON-DIS			
		SPEC PURPOSE COST CENTERS			
095		SUBTOTALS	371,518		371,518
		NONREIMBURS COST CENTERS			
100	01	COMMUNITY RELATIONS	2,358		2,358
100	02	OUTPATIENT MEALS			
100	03	CLINICAL TRIALS			
101		CROSS FOOT ADJUSTMENTS			
102		NEGATIVE COST CENTER			
103		TOTAL	373,876		373,876

		COST CENTER DESCRIPTION	NEW CAP REL COSTS-BLDG & (SQUARE FOOTAGE)	NEW CAP REL COSTS-MVBLE E (SQUARE FOOTAGE)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIV E & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FOOTAGE)
			3	4	5	6a.00	6	7
		GENERAL SERVICE COST						
003		NEW CAP REL COSTS-BLD	38,120					
004		NEW CAP REL COSTS-MVB		38,120				
005		EMPLOYEE BENEFITS	227	227	5,130,691			
006		ADMINISTRATIVE & GENE	5,860	5,860	1,525,501	-2,720,348	4,653,680	
007		MAINTENANCE & REPAIRS	1,022	1,022	71,570		266,774	31,011
009		LAUNDRY & LINEN SERVI	829	829			38,133	829
010		HOUSEKEEPING	839	839	47,644		75,657	839
011		DIETARY	3,559	3,559	137,597		329,787	3,559
012		CAFETERIA						
014		NURSING ADMINISTRATIO	228	228	216,164		256,309	228
014	01	MEDICAL ADMINISTRATIO	625	625	521,300		48,560	625
017		MEDICAL RECORDS & LIB	525	525	59,605		118,339	525
		INPAT ROUTINE SRVC CN						
025		ADULTS & PEDIATRICS	11,918	11,918	1,373,206		1,728,296	11,918
026		INTENSIVE CARE UNIT						
027		CORONARY CARE UNIT						
028		BURN INTENSIVE CARE U						
029		SURGICAL INTENSIVE CA						
033		NURSERY						
036		OTHER LONG TERM CARE	12,374	12,374	1,104,120		1,427,421	12,374
		ANCILLARY SRVC COST C						
044		LABORATORY	74	74			32,565	74
056		DRUGS CHARGED TO PATI					172,575	
059		PSYCHIATRIC/PSYCHOLOG					53,900	
		OUTPAT SERVICE COST C						
060		CLINIC						
061		EMERGENCY						
062		OBSERVATION BEDS (NON						
		SPEC PURPOSE COST CEN						
095		SUBTOTALS	38,080	38,080	5,056,707	-2,720,348	4,548,316	30,971
		NONREIMBURS COST CENT						
100	01	COMMUNITY RELATIONS	40	40	73,984		105,364	40
100	02	OUTPATIENT MEALS						
100	03	CLINICAL TRIALS						
101		CROSS FOOT ADJUSTMENT						
102		NEGATIVE COST CENTER						
103		COST TO BE ALLOCATED (WRKSHT B, PART I)	251,650	94,670	422,042		2,720,348	422,719
104		UNIT COST MULTIPLIER (WRKSHT B, PT I)	6.601522	2.483473	.082258		.584558	13.631260
105		COST TO BE ALLOCATED (WRKSHT B, PART II)						
106		UNIT COST MULTIPLIER (WRKSHT B, PT II)						
107		COST TO BE ALLOCATED (WRKSHT B, PART III			2,063		81,407	13,981
108		UNIT COST MULTIPLIER (WRKSHT B, PT III)			.000402		.017493	.450840

		COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE (DIRECT COST)	HOUSEKEEPING (SQUARE FOOTAGE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMIN ISTRATION (NURSING ADMIN H)	MEDICAL ADMIN ISTRATION (MEDICAL ADMIN T)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)
			9	10	11	12	14	14.01	17
		GENERAL SERVICE COST							
003		NEW CAP REL COSTS-BLD							
004		NEW CAP REL COSTS-MVB							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENE							
007		MAINTENANCE & REPAIRS							
009		LAUNDRY & LINEN SERVI	132,833						
010		HOUSEKEEPING		29,343					
011		DIETARY		3,559	56,301				
012		CAFETERIA			5,883	6,913			
014		NURSING ADMINISTRATIO		228		304	129,147		
014	01	MEDICAL ADMINISTRATIO		625				100	
017		MEDICAL RECORDS & LIB		525		253			17,874,153
		INPAT ROUTINE SRVC CN							
025		ADULTS & PEDIATRICS	53,091	11,918	20,151	3,055	63,544	100	12,043,175
026		INTENSIVE CARE UNIT							
027		CORONARY CARE UNIT							
028		BURN INTENSIVE CARE U							
029		SURGICAL INTENSIVE CA							
033		NURSERY							
036		OTHER LONG TERM CARE	79,742	12,374	30,267	3,154	65,603		5,296,725
		ANCILLARY SRVC COST C							
044		LABORATORY		74					131,175
056		DRUGS CHARGED TO PATI							277,027
059		PSYCHIATRIC/PSYCHOLOG							125,661
		OUTPAT SERVICE COST C							
060		CLINIC							390
061		EMERGENCY							
062		OBSERVATION BEDS (NON							
		SPEC PURPOSE COST CEN							
095		SUBTOTALS	132,833	29,303	56,301	6,766	129,147	100	17,874,153
		NONREIMBURS COST CENT							
100	01	COMMUNITY RELATIONS		40		147			
100	02	OUTPATIENT MEALS							
100	03	CLINICAL TRIALS							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		COST TO BE ALLOCATED (WRKSHT B, PART I)	71,724	131,320	587,009	61,338	412,961	88,263	199,266
104		UNIT COST MULTIPLIER (WRKSHT B, PT I)	.539956	4.475343	10.426262	8.872848	3.197604	882.630000	.011148
105		COST TO BE ALLOCATED (WRKSHT B, PART II)							
106		UNIT COST MULTIPLIER (WRKSHT B, PT II)							
107		COST TO BE ALLOCATED (WRKSHT B, PART III	8,573	9,343	40,896	4,273	7,006	7,218	7,424
108		UNIT COST MULTIPLIER (WRKSHT B, PT III)	.064540	.318406	.726381	.618111	.054248	72.180000	.000415

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	3,645,971		3,645,971		3,645,971
26	INTENSIVE CARE UNIT					
27	CORONARY CARE UNIT					
28	BURN INTENSIVE CARE UNIT					
29	SURGICAL INTENSIVE CARE U					
33	NURSERY					
36	OTHER LONG TERM CARE	3,141,315		3,141,315	4,018	3,145,333
	ANCILLARY SRVC COST CNTRS					
44	LABORATORY	54,403		54,403		54,403
56	DRUGS CHARGED TO PATIENTS	276,543		276,543		276,543
59	PSYCHIATRIC/PSYCHOLOGICAL	86,809		86,809		86,809
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	4		4		4
61	EMERGENCY					
62	OBSERVATION BEDS (NON-DIS					
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	7,205,045		7,205,045	4,018	7,209,063
102	LESS OBSERVATION BEDS					
103	TOTAL	7,205,045		7,205,045	4,018	7,209,063

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: 15-4041 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 4/10/2009 I WORKSHEET C 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 INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	12,043,175		12,043,175			
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
33	NURSERY						
36	OTHER LONG TERM CARE	5,296,725		5,296,725			
	ANCILLARY SRVC COST CNTRS						
44	LABORATORY	131,175		131,175	.414736	.414736	.414736
56	DRUGS CHARGED TO PATIENTS	277,027		277,027	.998253	.998253	.998253
59	PSYCHIATRIC/PSYCHOLOGICAL	125,661		125,661	.690819	.690819	.690819
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		390	390	.010256	.010256	.010256
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	17,873,763	390	17,874,153			
102	LESS OBSERVATION BEDS						
103	TOTAL	17,873,763	390	17,874,153			

Health Financial Systems MCRIF32 FOR BHC MEADOWS HOSPITAL **NOT A CMS WORKSHEET ** (05/1999)

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 15-4041 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 4/10/2009 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
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	3,645,971		3,645,971		3,645,971
26	INTENSIVE CARE UNIT					
27	CORONARY CARE UNIT					
28	BURN INTENSIVE CARE UNIT					
29	SURGICAL INTENSIVE CARE U					
33	NURSERY					
36	OTHER LONG TERM CARE	3,141,315		3,141,315	4,018	3,145,333
	ANCILLARY SRVC COST CNTRS					
44	LABORATORY	54,403		54,403		54,403
56	DRUGS CHARGED TO PATIENTS	276,543		276,543		276,543
59	PSYCHIATRIC/PSYCHOLOGICAL	86,809		86,809		86,809
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	4		4		4
61	EMERGENCY					
62	OBSERVATION BEDS (NON-DIS					
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	7,205,045		7,205,045	4,018	7,209,063
102	LESS OBSERVATION BEDS					
103	TOTAL	7,205,045		7,205,045	4,018	7,209,063

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 15-4041 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 4/10/2009 I WORKSHEET C PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	12,043,175		12,043,175			
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
33	NURSERY						
36	OTHER LONG TERM CARE	5,296,725		5,296,725			
	ANCILLARY SRVC COST CNTRS						
44	LABORATORY	131,175		131,175	.414736	.414736	.414736
56	DRUGS CHARGED TO PATIENTS	277,027		277,027	.998253	.998253	.998253
59	PSYCHIATRIC/PSYCHOLOGICAL	125,661		125,661	.690819	.690819	.690819
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		390	390	.010256	.010256	.010256
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	17,873,763	390	17,874,153			
102	LESS OBSERVATION BEDS						
103	TOTAL	17,873,763	390	17,874,153			

Health Financial Systems MCRIF32 FOR BHC MEADOWS HOSPITAL IN LIEU OF FORM CMS-2552-96(09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS

I PROVIDER NO: 15-4041 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 4/10/2009 I WORKSHEET C I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III,COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
	ANCILLARY SRVC COST CNTRS						
44	LABORATORY	54,403	1,354	53,049			54,403
56	DRUGS CHARGED TO PATIENTS	276,543	3,134	273,409			276,543
59	PSYCHIATRIC/PSYCHOLOGICAL	86,809	995	85,814			86,809
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	4		4			4
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	417,759	5,483	412,276			417,759
102	LESS OBSERVATION BEDS						
103	TOTAL	417,759	5,483	412,276			417,759

Health Financial Systems MCRIF32 FOR BHC MEADOWS HOSPITAL IN LIEU OF FORM CMS-2552-96(09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS

I PROVIDER NO: 15-4041 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 4/10/2009 I WORKSHEET C 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			
44	LABORATORY	131,175	.414736	.414736
56	DRUGS CHARGED TO PATIENTS	277,027	.998253	.998253
59	PSYCHIATRIC/PSYCHOLOGICAL	125,661	.690819	.690819
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	390	.010256	.010256
61	EMERGENCY			
62	OBSERVATION BEDS (NON-DIS			
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	534,253		
102	LESS OBSERVATION BEDS			
103	TOTAL	534,253		

Health Financial Systems MCRIF32 FOR BHC MEADOWS HOSPITAL **NOT A CMS WORKSHEET ** (09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 15-4041 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 4/10/2009 I WORKSHEET C I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III,COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
	ANCILLARY SRVC COST CNTRS						
44	LABORATORY	54,403	1,354	53,049	135	3,077	51,191
56	DRUGS CHARGED TO PATIENTS	276,543	3,134	273,409	313	15,858	260,372
59	PSYCHIATRIC/PSYCHOLOGICAL	86,809	995	85,814	100	4,977	81,732
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	4		4			4
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	417,759	5,483	412,276	548	23,912	393,299
102	LESS OBSERVATION BEDS						
103	TOTAL	417,759	5,483	412,276	548	23,912	393,299

Health Financial Systems MCRIF32 FOR BHC MEADOWS HOSPITAL **NOT A CMS WORKSHEET ** (09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 15-4041 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 4/10/2009 I WORKSHEET C 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			
44	LABORATORY	131,175	.390250	.413707
56	DRUGS CHARGED TO PATIENTS	277,027	.939880	.997123
59	PSYCHIATRIC/PSYCHOLOGICAL	125,661	.650417	.690023
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	390	.010256	.010256
61	EMERGENCY			
62	OBSERVATION BEDS (NON-DIS			
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	534,253		
102	LESS OBSERVATION BEDS			
103	TOTAL	534,253		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: 15-4041 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 4/10/2009 I WORKSHEET D PART I

TITLE XVIII, PART A PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL CAPITAL REL COST (B, II) 1	OLD CAPITAL SWING BED ADJUSTMENT 2	OLD CAPITAL REDUCED CAP RELATED COST 3	NEW CAPITAL CAPITAL REL COST (B,III) 4	NEW CAPITAL SWING BED ADJUSTMENT 5	NEW CAPITAL REDUCED CAP RELATED COST 6
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS				183,849		183,849
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
33	NURSERY						
101	TOTAL				183,849		183,849

Health Financial Systems MCRIF32 FOR BHC MEADOWS HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1997)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | PROVIDER NO: 15-4041 | PERIOD: FROM 1/ 1/2008 TO 12/31/2008 | PREPARED 4/10/2009 | WORKSHEET D | PART I

TITLE XVIII, PART A PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	INPAT PROGRAM OLD CAP CST 10	NEW CAPITAL PER DIEM 11	INPAT PROGRAM NEW CAP CST 12
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	6,717	401			27.37	10,975
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
33	NURSERY						
101	TOTAL	6,717	401				10,975

Health Financial Systems MCRIF32 FOR BHC MEADOWS HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1996)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: 15-4041 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 4/10/2009 I WORKSHEET D I PART II

I COMPONENT NO: 15-4041 I

TITLE XVIII, PART A HOSPITAL PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	OLD CAPITAL CST/CHRG RATIO 5	OLD CAPITAL COSTS 6
	ANCILLARY SRVC COST CNTRS						
44	LABORATORY		1,354	131,175	8,401		
56	DRUGS CHARGED TO PATIENTS		3,134	277,027	44,745		
59	PSYCHIATRIC/PSYCHOLOGICAL		995	125,661			
	OUTPAT SERVICE COST CNTRS						
60	CLINIC			390			
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
101	TOTAL		5,483	534,253	53,146		

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO:	I PERIOD:	I PREPARED	4/10/2009
I 15-4041	I FROM 1/ 1/2008	I WORKSHEET D	
I COMPONENT NO:	I TO 12/31/2008	I PART II	
I 15-4041	I	I	

TITLE XVIII, PART A HOSPITAL PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NEW CAPITAL CST/CHRG RATIO 7	COSTS 8
	ANCILLARY SRVC COST CNTRS		
44	LABORATORY	.010322	87
56	DRUGS CHARGED TO PATIENTS	.011313	506
59	PSYCHIATRIC/PSYCHOLOGICAL	.007918	
	OUTPAT SERVICE COST CNTRS		
60	CLINIC		
61	EMERGENCY		
62	OBSERVATION BEDS (NON-DIS		
	OTHER REIMBURS COST CNTRS		
101	TOTAL		593

Health Financial Systems MCRIF32 FOR BHC MEADOWS HOSPITAL

IN LIEU OF FORM CMS-2552-96(11/1998)

I PROVIDER NO: 15-4041 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 4/10/2009 I WORKSHEET D PART III

PPS

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

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	MED EDUCATN COST 2	SWING BED ADJ AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS					6,717	
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
33	NURSERY						
101	TOTAL					6,717	

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

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT PROG DAYS 7	INPAT PROGRAM PASS THRU COST 8
25	ADULTS & PEDIATRICS	401	
26	INTENSIVE CARE UNIT		
27	CORONARY CARE UNIT		
28	BURN INTENSIVE CARE UNIT		
29	SURGICAL INTENSIVE CARE U		
33	NURSERY		
101	TOTAL	401	

Health Financial Systems MCRIF32 FOR BHC MEADOWS HOSPITAL

IN LIEU OF FORM CMS-2552-96(04/2005)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

PROVIDER NO:	PERIOD:	PREPARED 4/10/2009
15-4041	FROM 1/ 1/2008	WORKSHEET D
COMPONENT NO:	TO 12/31/2008	PART IV
15-4041		

TITLE XVIII, PART A HOSPITAL PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	1.01	MED ED NRS SCHOOL COST 2	MED ED ALLIED HEALTH COST 2.01	MED ED ALL OTHER COSTS 2.02	BLOOD CLOT FOR HEMOPHILIACS 2.03
	ANCILLARY SRVC COST CNTRS						
44	LABORATORY						
56	DRUGS CHARGED TO PATIENTS						
59	PSYCHIATRIC/PSYCHOLOGICAL						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS							
44	LABORATORY			131,175			8,401	
56	DRUGS CHARGED TO PATIENTS			277,027			44,745	
59	PSYCHIATRIC/PSYCHOLOGICAL			125,661				
	OUTPAT SERVICE COST CNTRS							
60	CLINIC			390				
61	EMERGENCY							
62	OBSERVATION BEDS (NON-DIS							
	OTHER REIMBURS COST CNTRS							
101	TOTAL			534,253			53,146	

WKST A LINE NO.	COST CENTER DESCRIPTION	OUTPAT PROG CHARGES 8	OUTPAT PROG D,V COL 5.03 8.01	OUTPAT PROG D,V COL 5.04 8.02	OUTPAT PROG PASS THRU COST 9	COL 8.01 * COL 5 9.01	COL 8.02 * COL 5 9.02
	ANCILLARY SRVC COST CNTRS						
44	LABORATORY						
56	DRUGS CHARGED TO PATIENTS						
59	PSYCHIATRIC/PSYCHOLOGICAL						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	6,717
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,717
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,717
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	522
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,645,971
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,645,971
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	12,043,175
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	12,043,175
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.302742
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,792.94
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	3,645,971

TITLE V - 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	542.80
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	283,342
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	283,342

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT					
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					
						1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST					24,688
49	TOTAL PROGRAM INPATIENT COSTS					308,030

	PASS THROUGH COST ADJUSTMENTS	
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	
52	TOTAL PROGRAM EXCLUDABLE COST	
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	
	TARGET AMOUNT AND LIMIT COMPUTATION	
54	PROGRAM DISCHARGES	
55	TARGET AMOUNT PER DISCHARGE	
56	TARGET AMOUNT	
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	
58	BONUS PAYMENT	
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.	
58.04	RELIEF PAYMENT	
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT	
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)	
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1	
59.03	PROGRAM DISCHARGES AFTER JULY 1	
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)	
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)	
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	
	PROGRAM INPATIENT ROUTINE SWING BED COST	
60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:		PREPARED 4/10/2009
15-4041	FROM 1/ 1/2008		WORKSHEET D-1
COMPONENT NO:	TO 12/31/2008		PART III
15-4041			

TITLE V - I/P HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

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

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	6,717
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,717
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,717
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	401
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,645,971
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,645,971
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	12,043,175
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	12,043,175
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.302742
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,792.94
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	3,645,971

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	542.80
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	217,663
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	217,663

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT					
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					
						1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST					48,151
49	TOTAL PROGRAM INPATIENT COSTS					265,814

	PASS THROUGH COST ADJUSTMENTS	
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	10,975
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	593
52	TOTAL PROGRAM EXCLUDABLE COST	11,568
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	254,246

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	542.80
85	OBSERVATION BED COST	

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST		3,645,971			
87	NEW CAPITAL-RELATED COST	183,849	3,645,971	.050425		
88	NON PHYSICIAN ANESTHETIST		3,645,971			
89	MEDICAL EDUCATION		3,645,971			
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					