

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		PROVIDER NO:		PERIOD		INTERMEDIARY USE ONLY		DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY		26-3303		FROM 7/ 1/2007		--AUDITED --DESK REVIEW		/ /
				TO 6/30/2008		--INITIAL --REOPENED		INTERMEDIARY NO:
						--FINAL 1-MCR CODE		
						00 - # OF REOPENINGS		

ELECTRONICALLY FILED COST REPORT DATE: 11/13/2008 TIME 18:04

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:
 RANKEN JORDAN 26-3303

FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2007 AND ENDING 6/30/2008 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

		TITLE V	A	TITLE XVIII	B	TITLE XIX
		1	2	3	4	
1	HOSPITAL	0		10,969		0 1,998,939
100	TOTAL	0		10,969		0 1,998,939

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 & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

PROVIDER NO: 26-3303
 PERIOD: FROM 7/1/2007 TO 6/30/2008
 PREPARED 11/13/2008
 WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 11365 DORSETT ROAD P.O. BOX:
 1.01 CITY: MARYLAND HEIGHTS STATE: MO ZIP CODE: 63043- COUNTY: SAINT LOUIS

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O OR N)		
0	1	2	2.01	3	V	XVIII	XIX
02.00	HOSPITAL	26-3303		7/31/2002	4	5	6
					N	T	O

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 7/1/2007 TO: 6/30/2008

18 TYPE OF CONTROL

1 2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL
 20 SUBPROVIDER

7

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. 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. Y

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. 15-1, 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. 15-1, 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)

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

PROVIDER NO: 26-3303 PERIOD: FROM 7/1/2007 TO 6/30/2008 PREPARED 11/13/2008 WORKSHEET S-2

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

A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)
28.03 STAFFING % Y/N 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? DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)
30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70
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 ELIGIBLE 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 ELIGIBLE 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).
31.01 IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).
31.02 IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).
31.03 IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).
31.04 IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).
31.05 IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).

MISCELLANEOUS COST REPORT INFORMATION
32 IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2.
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
34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA?
35 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?
35.01 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?
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)
36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE

V XVIII XIX
1 2 3
N N N

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX
IDENTIFICATION DATA

PROVIDER NO:	PERIOD:	PREPARED 11/13/2008
26-3303	FROM 7/ 1/2007	WORKSHEET S-2
	TO 6/30/2008	

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

MULTI CAMPUS

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 COL. 1, STATE IN COL. 2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00
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

PROVIDER NO: 26-3303
PERIOD: FROM 7/1/2007 TO 6/30/2008
PREPARED 11/13/2008
WORKSHEET S-3
PART I

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH N/A 2.01	TITLE V 3	I/P DAYS / TITLE XVII 4	O/P VISITS / NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1 ADULTS & PEDIATRICS	34	12,444				80	4,514
2 HMO							3,067
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	34	12,444				80	4,514
12 TOTAL	34	12,444				80	4,514
13 RPCH VISITS							
25 TOTAL	34						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS / TOTAL ALL PATS 6	TRIPS TOTAL ADMITTED 6.01	OBSERVATION BEDS NOT ADMITTED 6.02	INTERNS & RES. FTES TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			9,291				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS			9,291				
12 TOTAL			9,291				
13 RPCH VISITS							
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 EMPLOYEES ON PAYROLL 10	EQUIV NONPAID WORKERS 11	TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS						85	224
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS						85	224
12 TOTAL		160.17			1	85	224
13 RPCH VISITS							
25 TOTAL		160.17					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

HOSPITAL UNCOMPENSATED CARE DATA

PROVIDER NO: 26-3303
 PERIOD: FROM 7/1/2007 TO 6/30/2008
 PREPARED 11/13/2008
 WORKSHEET S-10

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	
17.01	GROSS MEDICAID REVENUES	
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	
UNCOMPENSATED CARE COST		
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	20,437,102
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103)	.654797
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)	13,382,153
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	
27	TOTAL SCHIP COST, (LINE 24 * LINE 26)	
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	20,437,102

HOSPITAL UNCOMPENSATED CARE DATA

IN LIEU OF FORM CMS-2552-96 S-10 (05/2004)
PROVIDER NO: PERIOD: PREPARED 11/13/2008
26-3303 FROM 7/ 1/2007 WORKSHEET S-10
TO 6/30/2008

DESCRIPTION

29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	13,382,153
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)	26,764,306

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

PROVIDER NO: 26-3303
 PERIOD: FROM 7/ 1/2007 TO 6/30/2008
 PREPARED 11/13/2008
 WORKSHEET A

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		1,003,677	1,003,677	579,982	1,583,659
4	0400 NEW CAP REL COSTS-MVBLE EQUIP				261,311	261,311
5	0500 EMPLOYEE BENEFITS		1,814,888	1,814,888		1,814,888
6	0600 ADMINISTRATIVE & GENERAL	1,537,752	2,074,922	3,612,674	261,854	3,874,528
7	0700 MAINTENANCE & REPAIRS	307,946	427,668	735,614		735,614
11	1100 DIETARY	174,917	47,297	222,214		222,214
14	1400 NURSING ADMINISTRATION	189,444		189,444	308,940	498,384
18	1800 SOCIAL SERVICE	159,612	46,832	206,444		206,444
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	4,017,629	1,236,952	5,254,581	-585,754	4,668,827
	ANCILLARY SRVC COST CNTRS					
41	4100 RADIOLOGY-DIAGNOSTIC		62,646	62,646		62,646
44	4400 LABORATORY		109,712	109,712		109,712
49	4900 RESPIRATORY THERAPY	626,657	385,220	1,011,877		1,011,877
50	5000 PHYSICAL THERAPY	1,252,717	102,574	1,355,291	-68,078	1,287,213
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	112,481		112,481	276,814	389,295
56	5600 DRUGS CHARGED TO PATIENTS	174,268	772,987	947,255		947,255
	OUTPAT SERVICE COST CNTRS					
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		1,035,069	1,035,069	-1,035,069	
90	9000 OTHER CAPITAL RELATED COSTS					
95	SUBTOTALS	8,553,423	9,120,444	17,673,867	-0-	17,673,867
	NONREIMBURS COST CENTERS					
100	7950 RESPITE					
101	TOTAL	8,553,423	9,120,444	17,673,867	-0-	17,673,867

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 11/13/2008
I 26-3303 I FROM 7/ 1/2007 I WORKSHEET A
I I TO 6/30/2008 I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	304,193	1,887,852
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		261,311
5	0500 EMPLOYEE BENEFITS	-180,352	1,634,536
6	0600 ADMINISTRATIVE & GENERAL	-493,142	3,381,386
7	0700 MAINTENANCE & REPAIRS		735,614
11	1100 DIETARY		222,214
14	1400 NURSING ADMINISTRATION		498,384
18	1800 SOCIAL SERVICE		206,444
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-1,040,909	3,627,918
	ANCILLARY SRVC COST CNTRS		
41	4100 RADIOLOGY-DIAGNOSTIC		62,646
44	4400 LABORATORY		109,712
49	4900 RESPIRATORY THERAPY		1,011,877
50	5000 PHYSICAL THERAPY		1,287,213
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		389,295
56	5600 DRUGS CHARGED TO PATIENTS	-200	947,055
	OUTPAT SERVICE COST CNTRS		
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
90	9000 OTHER CAPITAL RELATED COSTS		-0-
95	SUBTOTALS	-1,410,410	16,263,457
	NONREIMBURS COST CENTERS		
100	7950 RESPITE		
101	TOTAL	-1,410,410	16,263,457

COST CENTERS USED IN COST REPORT

PROVIDER NO: 26-3303
 PERIOD: FROM 7/1/2007 TO 6/30/2008
 PREPARED 11/13/2008
 NOT A CMS WORKSHEET

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	
11	DIETARY	1100	
14	NURSING ADMINISTRATION	1400	
18	SOCIAL SERVICE	1800	
25	INPAT ROUTINE SRVC C ADULTS & PEDIATRICS	2500	
	ANCILLARY SRVC COST		
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	
	OUTPAT SERVICE COST		
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
100	RESPIRE	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO: 263303	PERIOD: FROM 7/1/2007 TO 6/30/2008	PREPARED 11/13/2008 WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION	----- INCREASE -----				
	CODE (1)	COST CENTER 2	LINE NO 3	SALARY 4	OTHER 5
1 TO RECLASS DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-MVBLE EQUIP	4		254,949
2 TO RECLASS INTEREST EXPENSE	B	NEW CAP REL COSTS-BLDG & FIXT	3		1,035,069
3 TO RECLASS PROPERTY INSURANCE	C	OTHER CAPITAL RELATED COSTS	90		56,729
4 TO RECLASS FRONT DESK SALARY	D	ADMINISTRATIVE & GENERAL	6	68,078	
5 TO RECLASS NURSING SUPERVISOR SALARY	E	NURSING ADMINISTRATION	14	308,940	
6 TO RECLASS MEDICAL SUPPLY EXPENSE	F	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		276,814
7 TO RECLASS HOSPITAL MALPRACTICE INS	G	ADMINISTRATIVE & GENERAL	6		193,776
36 TOTAL RECLASSIFICATIONS				377,018	1,817,337

(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: 263303	PERIOD: FROM 7/1/2007 TO 6/30/2008	PREPARED 11/13/2008 WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE		SALARY	OTHER	A-7 REF 10
			6	7			
1 TO RECLASS DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT		3		254,949	9
2 TO RECLASS INTEREST EXPENSE	B	INTEREST EXPENSE		88		1,035,069	11
3 TO RECLASS PROPERTY INSURANCE	C	NEW CAP REL COSTS-BLDG & FIXT		3		56,729	12
4 TO RECLASS FRONT DESK SALARY	D	PHYSICAL THERAPY		50	68,078		
5 TO RECLASS NURSING SUPERVISOR SALARY	E	ADULTS & PEDIATRICS		25	308,940		
6 TO RECLASS MEDICAL SUPPLY EXPENSE	F	ADULTS & PEDIATRICS		25		276,814	
7 TO RECLASS HOSPITAL MALPRACTICE INS	G	NEW CAP REL COSTS-BLDG & FIXT		3		193,776	12
36 TOTAL RECLASSIFICATIONS					377,018	1,817,337	

(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: 263303	PERIOD: FROM 7/1/2007 TO 6/30/2008	PREPARED 11/13/2008 WORKSHEET A-6 NOT A CMS WORKSHEET
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RECLASS CODE: A
EXPLANATION : TO RECLASS DEPRECIATION EXPENSE

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	254,949	NEW CAP REL COSTS-BLDG & FIXT	3	254,949	
TOTAL RECLASSIFICATIONS FOR CODE A			254,949				254,949

RECLASS CODE: B
EXPLANATION : TO RECLASS INTEREST EXPENSE

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	1,035,069	INTEREST EXPENSE	88	1,035,069	
TOTAL RECLASSIFICATIONS FOR CODE B			1,035,069				1,035,069

RECLASS CODE: C
EXPLANATION : TO RECLASS PROPERTY INSURANCE

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	OTHER CAPITAL RELATED COSTS	90	56,729	NEW CAP REL COSTS-BLDG & FIXT	3	56,729	
TOTAL RECLASSIFICATIONS FOR CODE C			56,729				56,729

RECLASS CODE: D
EXPLANATION : TO RECLASS FRONT DESK SALARY

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ADMINISTRATIVE & GENERAL	6	68,078	PHYSICAL THERAPY	50	68,078	
TOTAL RECLASSIFICATIONS FOR CODE D			68,078				68,078

RECLASS CODE: E
EXPLANATION : TO RECLASS NURSING SUPERVISOR SALARY

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NURSING ADMINISTRATION	14	308,940	ADULTS & PEDIATRICS	25	308,940	
TOTAL RECLASSIFICATIONS FOR CODE E			308,940				308,940

RECLASS CODE: F
EXPLANATION : TO RECLASS MEDICAL SUPPLY EXPENSE

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	276,814	ADULTS & PEDIATRICS	25	276,814	
TOTAL RECLASSIFICATIONS FOR CODE F			276,814				276,814

RECLASS CODE: G
EXPLANATION : TO RECLASS HOSPITAL MALPRACTICE INS

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ADMINISTRATIVE & GENERAL	6	193,776	NEW CAP REL COSTS-BLDG & FIXT	3	193,776	
TOTAL RECLASSIFICATIONS FOR CODE G			193,776				193,776

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS DONATION 3	TOTAL 4	DI SPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1 LAND							
2 LAND IMPROVEMENTS							
3 BUILDINGS & FIXTURE							
4 BUILDING IMPROVEMENT							
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	DI SPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1 LAND	2,359,177					2,359,177	
2 LAND IMPROVEMENTS							
3 BUILDINGS & FIXTURE	19,241,456	257,637		257,637		19,499,093	
4 BUILDING IMPROVEMENT							
5 FIXED EQUIPMENT							
6 MOVABLE EQUIPMENT	1,912,634	589,478		589,478	39,162	2,462,950	
7 SUBTOTAL	23,513,267	847,115		847,115	39,162	24,321,220	
8 RECONCILING ITEMS							
9 TOTAL	23,513,267	847,115		847,115	39,162	24,321,220	

PART III - RECONCILIATION OF CAPITAL COST CENTERS
 DESCRIPTION

	DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL
		GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO 3	RATIO 4	INSURANCE 5	TAXES 6	
*								8
3	NEW CAP REL COSTS-BL	19,499,093		19,499,093	.887854	50,367		50,367
4	NEW CAP REL COSTS-MV	2,462,950		2,462,950	.112146	6,362		6,362
5	TOTAL	21,962,043		21,962,043	1.000000	56,729		56,729

DESCRIPTION

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	486,436		988,145	50,368	7,899	355,004	1,887,852
4	NEW CAP REL COSTS-MV	254,949			6,362			261,311
5	TOTAL	741,385		988,145	56,730	7,899	355,004	2,149,163

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

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	741,385			250,506	7,899	3,887	1,003,677
4	NEW CAP REL COSTS-MV							
5	TOTAL	741,385			250,506	7,899	3,887	1,003,677

* All lines numbers except line 5 are to be consistent with Workshseet 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

DESCR I PT I O N (1)	(2) BAS I S /CO D E 1	AMOUNT 2	EXPENSE CLASS I F I C A T I O N O N WORKSHEET A TO/FROM WH I C H THE AMOUNT I S TO BE ADJUSTED		WKST. A-7 REF. 5
			COST CENTER 3	LINE NO 4	
1 INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3 INVST INCOME-NEW BLDGS AND FIXTURES	B	-46,924	NEW CAP REL COSTS-BLDG &	3	11
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5 INVESTMENT INCOME-OTHER					
6 TRADE, QUANTI TY 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	-1,040,909			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATI ON TRANSACTIONS	A-8-1				
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS					
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS					
18 SALE OF MED AND SURG SUPPLIES					
19 SALE OF DRUGS TO OTHER THAN PATIENTS					
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-6,120	ADMINISTRATIVE & GENERAL	6	
21 NURSG SCHOOL(TUITN, FEES, BOOKS, ETC.)					
22 VENDING MACHINES					
23 INCOME FROM IMPOSITION OF INTEREST					
24 INTRST EXP ON MEDI CARE 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 UTILIZATI ON REVI EW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34 PHYSICIANS' ASSISTANT					
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37 PHYSICIAN BENEFITS	A	-144,298	EMPLOYEE BENEFITS	5	
38 LOBBYING EXPENSE	A	-11,658	ADMINISTRATIVE & GENERAL	6	
39 DEVELOPMENT SALARIES	A	-160,385	ADMINISTRATIVE & GENERAL	6	
40 DEVELOPMENT BENEFITS	A	-34,030	EMPLOYEE BENEFITS	5	
41 DEVELOPMENT OTHER EXPENSES	A	-72,127	ADMINISTRATIVE & GENERAL	6	
42 MISCELLANEOUS REVENUE	B	-2,024	EMPLOYEE BENEFITS	5	
43 MISCELLANEOUS REVENUE	B	-117,050	ADMINISTRATIVE & GENERAL	6	
44 MISCELLANEOUS REVENUE	B	-200	DRUGS CHARGED TO PATIENTS	56	
45 NON-ALLOWABLE MARKETING	A	-153,410	ADMINISTRATIVE & GENERAL	6	
46 LOSS ON EXTINGUISHMENT OF DEBT	A	351,117	NEW CAP REL COSTS-BLDG &	3	14
47 TRAVEL NON PATIENT CARE	A	-4,895	ADMINISTRATIVE & GENERAL	6	
48 COUNTRY CLUB DUES	A	-10,573	ADMINISTRATIVE & GENERAL	6	
49 HEALTHLINK EXPENSE	A	43,076	ADMINISTRATIVE & GENERAL	6	
49.01					
50 TOTAL (SUM OF LINES 1 THRU 49)		-1,410,410			

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(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

IN LIEU OF FORM CMS-2552-96(9/1996)
 I PROVIDER NO: I PERIOD: I PREPARED 11/13/2008
 I 26-3303 I FROM 7/ 1/2007 I WORKSHEET A-8-2
 I I TO 6/30/2008 I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	25 ADULTS & PEDS	1,075,219	1,040,909	34,310	140,600	520	35,150	1,758
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
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16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	1,075,219	1,040,909	34,310		520	35,150	1,758

PROVIDER BASED PHYSICIAN ADJUSTMENTS

PROVIDER NO: 26-3303
 PERIOD: FROM 7/1/2007 TO 6/30/2008
 PREPARED 11/13/2008
 WORKSHEET A-8-2
 GROUP 1

LINE NO.	WKSHT A IDENTIFIER	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF COL 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COL 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
	10	11	12	13	14	15	16	17	18
1	25	ADULTS & PEDS			112,728	3,597	38,747		1,040,909
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL			112,728	3,597	38,747		1,040,909

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 11/13/2008
 I 26-3303 I FROM 7/ 1/2007 I NOT A CMS WORKSHEET
 I I TO 6/30/2008 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	5	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	3	SQUARE	FEET	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	ENTERED
18	SOCIAL SERVICE	17	TIME	SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER NO: 26-3303
 PERIOD: FROM 7/1/2007 TO 6/30/2008
 PREPARED 11/13/2008
 WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENEFITS	SUBTOTAL	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
	0	3	4	5	5a.00	6	7
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	1,887,852	1,887,852					
005 NEW CAP REL COSTS-MVBLE E	261,311		261,311				
006 EMPLOYEE BENEFITS	1,634,536			1,634,536			
007 ADMINISTRATIVE & GENERAL	3,381,386	309,130	42,789	306,319	4,039,624	4,039,624	
011 MAINTENANCE & REPAIRS	735,614	309,944	42,902	65,260	1,153,720	381,271	1,534,991
014 DIETARY	222,214	50,765	7,027	37,068	317,074	104,784	61,416
018 NURSING ADMINISTRATION	498,384	123,420	17,083	105,618	744,505	246,037	149,316
025 SOCIAL SERVICE	206,444	48,322	6,689	33,825	295,280	97,581	58,461
041 INPAT ROUTINE SRVC CNTRS							
044 ADULTS & PEDIATRICS	3,627,918	890,093	123,203	641,828	5,283,042	1,745,894	1,076,851
049 ANCILLARY SRVC COST CNTRS							
050 RADIOLOGY-DIAGNOSTIC	62,646				62,646	20,703	
055 LABORATORY	109,712				109,712	36,257	
056 RESPIRATORY THERAPY	1,011,877			132,801	1,144,678	378,283	
062 PHYSICAL THERAPY	1,287,213	156,178	21,618	251,049	1,716,058	567,107	188,947
095 MEDICAL SUPPLIES CHARGED	389,295			23,837	413,132	136,528	
100 DRUGS CHARGED TO PATIENTS	947,055			36,931	983,986	325,179	
101 OUTPAT SERVICE COST CNTRS							
102 OBSERVATION BEDS (NON-DIS							
103 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	16,263,457	1,887,852	261,311	1,634,536	16,263,457	4,039,624	1,534,991
100 NONREIMBURS COST CENTERS							
101 RESPITE							
102 CROSS FOOT ADJUSTMENT							
103 NEGATIVE COST CENTER							
TOTAL	16,263,457	1,887,852	261,311	1,634,536	16,263,457	4,039,624	1,534,991

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	DIETARY	NURSING ADMINISTRATION	SOCIAL SERVICE	SUBTOTAL	I&R COST POST STEP-DOWN ADJ 26	TOTAL
003 GENERAL SERVICE COST CNTR	11	14	18	25		27
004 NEW CAP REL COSTS-BLDG &						
005 NEW CAP REL COSTS-MVBLE E						
006 EMPLOYEE BENEFITS						
007 ADMINISTRATIVE & GENERAL						
011 MAINTENANCE & REPAIRS						
014 DIETARY	483,274					
018 NURSING ADMINISTRATION		1,139,858				
025 SOCIAL SERVICE			451,322			
041 INPAT ROUTINE SRVC CNTRS						
044 ADULTS & PEDIATRICS	483,274	1,139,858	451,322	10,180,241		10,180,241
049 ANCILLARY SRVC COST CNTRS						
050 RADIOLOGY-DIAGNOSTIC				83,349		83,349
055 LABORATORY				145,969		145,969
056 RESPIRATORY THERAPY				1,522,961		1,522,961
062 PHYSICAL THERAPY				2,472,112		2,472,112
100 MEDICAL SUPPLIES CHARGED				549,660		549,660
101 DRUGS CHARGED TO PATIENTS				1,309,165		1,309,165
102 OUTPAT SERVICE COST CNTRS						
103 OBSERVATION BEDS (NON-DIS						
104 SPEC PURPOSE COST CENTERS						
105 SUBTOTALS	483,274	1,139,858	451,322	16,263,457		16,263,457
106 NONREIMBURS COST CENTERS						
107 RESPITE						
108 CROSS FOOT ADJUSTMENT						
109 NEGATIVE COST CENTER						
110 TOTAL	483,274	1,139,858	451,322	16,263,457		16,263,457

ALLOCATION OF NEW CAPITAL RELATED COSTS

PROVIDER NO: 26-3303
 PERIOD: FROM 7/1/2007 TO 6/30/2008
 PREPARED 11/13/2008
 WORKSHEET B
 PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
	0	3	4	4a	5	6	7
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL	32,770	309,130	42,789	384,689		384,689	
011 MAINTENANCE & REPAIRS	1,303	309,944	42,902	354,149		36,308	390,457
014 DIETARY		50,765	7,027	57,792		9,978	15,623
018 NURSING ADMINISTRATION		123,420	17,083	140,503		23,430	37,982
025 SOCIAL SERVICE		48,322	6,689	55,011		9,292	14,871
041 INPAT ROUTINE SRVC CNTRS		890,093	123,203	1,013,296		166,263	273,918
044 ADULTS & PEDIATRICS							
049 ANCILLARY SRVC COST CNTRS							
050 RADIOLOGY-DIAGNOSTIC						1,971	
055 LABORATORY						3,453	
056 RESPIRATORY THERAPY	84,740			84,740		36,023	
062 PHYSICAL THERAPY	540	156,178	21,618	178,336		54,004	48,063
095 MEDICAL SUPPLIES CHARGED	82,243			82,243		13,001	
100 DRUGS CHARGED TO PATIENTS						30,966	
101 OUTPAT SERVICE COST CNTRS							
102 OBSERVATION BEDS (NON-DIS							
103 SPEC PURPOSE COST CENTERS							
100 SUBTOTALS	201,596	1,887,852	261,311	2,350,759		384,689	390,457
101 NONREIMBURS COST CENTERS							
102 RESPITE							
103 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	201,596	1,887,852	261,311	2,350,759		384,689	390,457

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	DIETARY	NURSING ADMINISTRATION	SOCIAL SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	11	14	18	25	26	27
003 GENERAL SERVICE COST CNTR						
004 NEW CAP REL COSTS-BLDG &						
005 NEW CAP REL COSTS-MVBLE E						
006 EMPLOYEE BENEFITS						
007 ADMINISTRATIVE & GENERAL						
011 MAINTENANCE & REPAIRS						
014 DIETARY	83,393					
018 NURSING ADMINISTRATION		201,915				
025 SOCIAL SERVICE			79,174			
041 INPAT ROUTINE SRVC CNTRS						
044 ADULTS & PEDIATRICS	83,393	201,915	79,174	1,817,959		1,817,959
049 ANCILLARY SRVC COST CNTRS						
050 RADIOLOGY-DIAGNOSTIC				1,971		1,971
055 LABORATORY				3,453		3,453
056 RESPIRATORY THERAPY				120,763		120,763
062 PHYSICAL THERAPY				280,403		280,403
095 MEDICAL SUPPLIES CHARGED				95,244		95,244
100 DRUGS CHARGED TO PATIENTS				30,966		30,966
101 OUTPAT SERVICE COST CNTRS						
102 OBSERVATION BEDS (NON-DIS						
103 SPEC PURPOSE COST CENTERS						
095 SUBTOTALS	83,393	201,915	79,174	2,350,759		2,350,759
100 NONREIMBURS COST CENTERS						
101 RESPITE						
102 CROSS FOOT ADJUSTMENTS						
103 NEGATIVE COST CENTER						
TOTAL	83,393	201,915	79,174	2,350,759		2,350,759

COST ALLOCATION - STATISTICAL BASIS

PROVIDER NO: 26-3303
 PERIOD: FROM 7/1/2007 TO 6/30/2008
 PREPARED 11/13/2008
 WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE	EMPLOYEE BENEFITS	RECONCILIATION	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
	(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARIES)		(ACCUM. COST)	(SQUARE FEET)
	3	4	5	6a.00	6	7
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	60,282					
005 NEW CAP REL COSTS-MVB		60,282				
006 EMPLOYEE BENEFITS			7,712,972			
007 ADMINISTRATIVE & GENERAL	9,871	9,871	1,445,445	-4,039,624	12,223,833	
011 MAINTENANCE & REPAIRS	9,897	9,897	307,946		1,153,720	40,514
014 DIETARY	1,621	1,621	174,917		317,074	1,621
018 NURSING ADMINISTRATION	3,941	3,941	498,384		744,505	3,941
025 SOCIAL SERVICE	1,543	1,543	159,612		295,280	1,543
041 INPAT ROUTINE SRVC CN						
044 ADULTS & PEDIATRICS	28,422	28,422	3,028,623		5,283,042	28,422
049 ANCILLARY SRVC COST C					62,646	
050 RADIOLOGY-DIAGNOSTIC					109,712	
055 LABORATORY			626,657		1,144,678	
056 RESPIRATORY THERAPY	4,987	4,987	1,184,639		1,716,058	4,987
062 PHYSICAL THERAPY			112,481		413,132	
095 MEDICAL SUPPLIES CHARGED TO PATIENTS			174,268		983,986	
100 OUTPAT SERVICE COST CENTER						
101 OBSERVATION BEDS (NON SPEC PURPOSE COST CENTER)						
102 SUBTOTALS	60,282	60,282	7,712,972	-4,039,624	12,223,833	40,514
103 NONREIMBURS COST CENTER						
104 RESPIRE						
105 CROSS FOOT ADJUSTMENT						
106 NEGATIVE COST CENTER						
107 COST TO BE ALLOCATED (WRKSHT B, PART I)	1,887,852	261,311	1,634,536		4,039,624	1,534,991
108 UNIT COST MULTIPLIER (WRKSHT B, PT I)	31.317010		.211920		.330471	
109 COST TO BE ALLOCATED (WRKSHT B, PART II)		4.334810				37.887915
110 UNIT COST MULTIPLIER (WRKSHT B, PT II)						
111 COST TO BE ALLOCATED (WRKSHT B, PART III)					384,689	390,457
112 UNIT COST MULTIPLIER (WRKSHT B, PT III)					.031470	9.637582

COST ALLOCATION - STATISTICAL BASIS

PROVIDER NO: 26-3303
 PERIOD: FROM 7/1/2007 TO 6/30/2008
 PREPARED 11/13/2008
 WORKSHEET B-1

	COST CENTER DESCRIPTION	DIETARY	NURSING ADMINISTRATION	SOCIAL SERVICE
		(MEALS SERVED)	(DIRECT NRSING HRS)	(TIME SPENT)
	GENERAL SERVICE COST	11	14	18
003	NEW CAP REL COSTS-BLD			
004	NEW CAP REL COSTS-MVB			
005	EMPLOYEE BENEFITS			
006	ADMINISTRATIVE & GENERAL			
007	MAINTENANCE & REPAIRS			
011	DIETARY	9,291		
014	NURSING ADMINISTRATION		131,420	
018	SOCIAL SERVICE			8,889
025	INPAT ROUTINE SRVC CN ADULTS & PEDIATRICS	9,291	131,420	8,889
041	ANCILLARY SRVC COST C			
044	RADIOLOGY-DIAGNOSTIC LABORATORY			
049	RESPIRATORY THERAPY			
050	PHYSICAL THERAPY			
055	MEDICAL SUPPLIES CHAR			
056	DRUGS CHARGED TO PATI			
062	OUTPAT SERVICE COST C			
095	OBSERVATION BEDS (NON SPEC PURPOSE COST CEN SUBTOTALS	9,291	131,420	8,889
100	NONREIMBURS COST CENT			
101	RESPIRE			
102	CROSS FOOT ADJUSTMENT			
103	NEGATIVE COST CENTER COST TO BE ALLOCATED (PER WRKSHT B, PART	483,274	1,139,858	451,322
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)		8.673398	
105	COST TO BE ALLOCATED (PER WRKSHT B, PART	52.015284		50.773090
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)			
107	COST TO BE ALLOCATED (PER WRKSHT B, PART	83,393	201,915	79,174
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	8.975675	1.536410	8.906964

COMPUTATION OF RATIO OF COSTS TO CHARGES

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 ANCILLARY SRVC COST CNTRS	10,180,241		10,180,241		
41	RADIOLOGY-DIAGNOSTIC	83,349		83,349		
44	LABORATORY	145,969		145,969		
49	RESPIRATORY THERAPY	1,522,961		1,522,961		
50	PHYSICAL THERAPY	2,472,112		2,472,112		
55	MEDICAL SUPPLIES CHARGED	549,660		549,660		
56	DRUGS CHARGED TO PATIENTS	1,309,165		1,309,165		
62	OUTPAT SERVICE COST CNTRS OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	16,263,457		16,263,457		
102	LESS OBSERVATION BEDS					
103	TOTAL	16,263,457		16,263,457		

COMPUTATION OF RATIO OF COSTS TO CHARGES

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 ANCILLARY SRVC COST CNTRS	16,723,800		16,723,800			
41	RADIOLOGY-DIAGNOSTIC	83,131		83,131	1.002622	1.002622	
44	LABORATORY	257,469		257,469	.566938	.566938	
49	RESPIRATORY THERAPY	4,636,997		4,636,997	.328437	.328437	
50	PHYSICAL THERAPY	1,105,369	687,796	1,793,165	1.378631	1.378631	
55	MEDICAL SUPPLIES CHARGED	689,589		689,589	.797083	.797083	
56	DRUGS CHARGED TO PATIENTS	653,248		653,248	2.004086	2.004086	
62	OUTPAT SERVICE COST CNTRS OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	24,149,603	687,796	24,837,399			
102	LESS OBSERVATION BEDS						
103	TOTAL	24,149,603	687,796	24,837,399			

COMPUTATION OF RATIO OF COSTS TO CHARGES
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DI ALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS ANCILLARY SRVC COST CNTRS	10,180,241		10,180,241		
41	RADIOLOGY-DIAGNOSTIC	83,349		83,349		
44	LABORATORY	145,969		145,969		
49	RESPIRATORY THERAPY	1,522,961		1,522,961		
50	PHYSICAL THERAPY	2,472,112		2,472,112		
55	MEDICAL SUPPLIES CHARGED	549,660		549,660		
56	DRUGS CHARGED TO PATIENTS	1,309,165		1,309,165		
62	OUTPAT SERVICE COST CNTRS OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	16,263,457		16,263,457		
102	LESS OBSERVATION BEDS					
103	TOTAL	16,263,457		16,263,457		

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

PROVIDER NO: 26-3303
PERIOD: FROM 7/1/2007 TO 6/30/2008
PREPARED 11/13/2008
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 INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS ANCILLARY SRVC COST CNTRS	16,723,800		16,723,800			
41	RADIOLOGY-DIAGNOSTIC	83,131		83,131	1.002622	1.002622	
44	LABORATORY	257,469		257,469	.566938	.566938	
49	RESPIRATORY THERAPY	4,636,997		4,636,997	.328437	.328437	
50	PHYSICAL THERAPY	1,105,369	687,796	1,793,165	1.378631	1.378631	
55	MEDICAL SUPPLIES CHARGED	689,589		689,589	.797083	.797083	
56	DRUGS CHARGED TO PATIENTS	653,248		653,248	2.004086	2.004086	
62	OUTPAT SERVICE COST CNTRS OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	24,149,603	687,796	24,837,399			
102	LESS OBSERVATION BEDS						
103	TOTAL	24,149,603	687,796	24,837,399			

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
41	ANCILLARY SRVC COST CNTRS						
	RADIOLOGY-DIAGNOSTIC	83,349	1,971	81,378			83,349
44	LABORATORY	145,969	3,453	142,516			145,969
49	RESPIRATORY THERAPY	1,522,961	120,763	1,402,198			1,522,961
50	PHYSICAL THERAPY	2,472,112	280,403	2,191,709			2,472,112
55	MEDICAL SUPPLIES CHARGED	549,660	95,244	454,416			549,660
56	DRUGS CHARGED TO PATIENTS	1,309,165	30,966	1,278,199			1,309,165
62	OUTPAT SERVICE COST CNTRS OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	6,083,216	532,800	5,550,416			6,083,216
102	LESS OBSERVATION BEDS						
103	TOTAL	6,083,216	532,800	5,550,416			6,083,216

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
41	ANCILLARY SRVC COST CNTRS			
	RADIOLOGY-DIAGNOSTIC	83,131	1.002622	1.002622
44	LABORATORY	257,469	.566938	.566938
49	RESPIRATORY THERAPY	4,636,997	.328437	.328437
50	PHYSICAL THERAPY	1,793,165	1.378631	1.378631
55	MEDICAL SUPPLIES CHARGED	689,589	.797083	.797083
56	DRUGS CHARGED TO PATIENTS	653,248	2.004086	2.004086
62	OUTPAT SERVICE COST CNTRS			
	OBSERVATION BEDS (NON-DIS			
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	8,113,599		
102	LESS OBSERVATION BEDS			
103	TOTAL	8,113,599		

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
41	ANCILLARY SRVC COST CNTRS	83,349	1,971	81,378			83,349
44	RADIOLOGY-DIAGNOSTIC	145,969	3,453	142,516			145,969
49	LABORATORY	1,522,961	120,763	1,402,198			1,522,961
50	RESPIRATORY THERAPY	2,472,112	280,403	2,191,709			2,472,112
55	PHYSICAL THERAPY	549,660	95,244	454,416			549,660
56	MEDICAL SUPPLIES CHARGED	1,309,165	30,966	1,278,199			1,309,165
62	DRUGS CHARGED TO PATIENTS						
	OUTPAT SERVICE COST CNTRS						
	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	6,083,216	532,800	5,550,416			6,083,216
102	LESS OBSERVATION BEDS						
103	TOTAL	6,083,216	532,800	5,550,416			6,083,216

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	7	8	9	OUTPUT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC	83,131		1.002622		1.002622	
44	LABORATORY	257,469		.566938		.566938	
49	RESPIRATORY THERAPY	4,636,997		.328437		.328437	
50	PHYSICAL THERAPY	1,793,165		1.378631		1.378631	
55	MEDICAL SUPPLIES CHARGED	689,589		.797083		.797083	
56	DRUGS CHARGED TO PATIENTS	653,248		2.004086		2.004086	
62	OUTPAT SERVICE COST CNTRS OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	8,113,599					
102	LESS OBSERVATION BEDS						
103	TOTAL	8,113,599					

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

PROVIDER NO: 26-3303 PERIOD: FROM 7/1/2007 TO 6/30/2008 PREPARED 11/13/2008 WORKSHEET D PART I

TEFRA

TITLE XVIII, PART A

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
		CAPITAL REL COST (B, 11) 1	SWING BED ADJUSTMENT 2	REDUCED CAP RELATED COST 3	CAPITAL REL COST (B, 111) 4	SWING BED ADJUSTMENT 5	REDUCED CAP RELATED COST 6
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS				1,817,959		1,817,959
101	TOTAL				1,817,959		1,817,959

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/13/2008
 I 26-3303 I FROM 7/ 1/2007 I WORKSHEET D
 I I TO 6/30/2008 I PART I
 TEFRA

TITLE XVIII, PART A

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	INPAT PROGRAM OLD CAP CST 10	NEW CAPITAL PER DIEM 11	INPAT PROGRAM NEW CAP CST 12
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	9,291	80			195.67	15,654
101	TOTAL	9,291	80				15,654

I PROVIDER NO: I PERIOD: I PREPARED 11/13/2008
 I 26-3303 I FROM 7/ 1/2007 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2008 I PART II
 I 26-3303 I I

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

TITLE XVIII, PART A

HOSPITAL

TEFRA

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	CAPITAL COSTS 6
41	ANCILLARY SRVC COST CNTRS		1,971	83,131			
44	RADIOLOGY-DIAGNOSTIC		3,453	257,469	1,887		
49	LABORATORY		120,763	4,636,997			
50	RESPIRATORY THERAPY		280,403	1,793,165	3,843		
55	PHYSICAL THERAPY		95,244	689,589	13,178		
56	MEDICAL SUPPLIES CHARGED		30,966	653,248	11,820		
	DRUGS CHARGED TO PATIENTS						
62	OUTPAT SERVICE COST CNTRS						
	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
101	TOTAL		532,800	8,113,599	30,728		

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

IN LIEU OF FORM CMS-2552-96(09/1996) CONTD
 I PROVIDER NO: I PERIOD: I PREPARED 11/13/2008
 I 26-3303 I FROM 7/ 1/2007 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2008 I PART II
 I 26-3303 I
 TEFRA

TITLE XVIII, PART A HOSPITAL

WKST A LINE NO.	COST CENTER DESCRIPTION	NEW CAPITAL	
		CST/CHRG 7	RATIO COSTS 8
41	ANCILLARY SRVC COST CNTRS		
	RADIOLOGY-DIAGNOSTIC	.023710	
44	LABORATORY	.013411	25
49	RESPIRATORY THERAPY	.026043	
50	PHYSICAL THERAPY	.156373	601
55	MEDICAL SUPPLIES CHARGED	.138117	1,820
56	DRUGS CHARGED TO PATIENTS	.047403	560
62	OUTPAT SERVICE COST CNTRS		
	OBSERVATION BEDS (NON-DIS		
	OTHER REIMBURS COST CNTRS		
101	TOTAL		3,006

PROVIDER NO: 26-3303
 PERIOD: FROM 7/1/2007 TO 6/30/2008
 PREPARED 11/13/2008
 WORKSHEET D
 PART III
 TEFRA

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
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS					9,291	
101	TOTAL					9,291	

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

I PROVIDER NO: I PERIOD: I PREPARED 11/13/2008
I 26-3303 I FROM 7/ 1/2007 I WORKSHEET D
I TO 6/30/2008 I PART III

WKST A	COST CENTER DESCRIPTION	INPATIENT	INPAT PROGRAM
LINE NO.		PROG DAYS	PASS THRU COST
		7	8
25	ADULTS & PEDIATRICS		80
101	TOTAL		80

TITLE XVIII, PART A

HOSPITAL

TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST		MED ED NRS SCHOOL COST	MED ED ALLIED HEALTH COST	MED ED ALL OTHER COSTS	BLOOD CLOT FOR HEMOPHILIACS
		1	1.01	2	2.01	2.02	2.03
41	ANCILLARY SRVC COST CNTRS						
44	RADIOLOGY-DIAGNOSTIC						
49	LABORATORY						
50	RESPIRATORY THERAPY						
55	PHYSICAL THERAPY						
56	MEDICAL SUPPLIES CHARGED						
	DRUGS CHARGED TO PATIENTS						
62	OUTPAT SERVICE COST CNTRS						
	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

TITLE XVIII, PART A

HOSPITAL

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
41	ANCILLARY SRVC COST CNTRS			83,131				
44	RADIOLOGY-DIAGNOSTIC			257,469			1,887	
49	LABORATORY			4,636,997				
50	RESPIRATORY THERAPY			1,793,165			3,843	
55	PHYSICAL THERAPY			689,589			13,178	
56	MEDICAL SUPPLIES CHARGED			653,248			11,820	
	DRUGS CHARGED TO PATIENTS							
62	OUTPAT SERVICE COST CNTRS							
	OBSERVATION BEDS (NON-DIS							
	OTHER REIMBURS COST CNTRS							
101	TOTAL			8,113,599			30,728	

TITLE XVIII, PART A

HOSPITAL

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
41	ANCILLARY SRVC COST CNTRS						
44	RADIOLOGY-DIAGNOSTIC						
49	LABORATORY						
50	RESPIRATORY THERAPY						
55	PHYSICAL THERAPY						
56	MEDICAL SUPPLIES CHARGED						
	DRUGS CHARGED TO PATIENTS						
62	OUTPAT SERVICE COST CNTRS						
	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: | PERIOD: | PREPARED 11/13/2008
 | 26-3303 | FROM 7/ 1/2007 | WORKSHEET D
 | COMPONENT NO: | TO 6/30/2008 | PART V
 | 26-3303 | |

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1)
	1	2	3	4	5
(A) ANCILLARY SRVC COST CNTRS					
41 RADIOLOGY-DIAGNOSTIC	1.002622				
44 LABORATORY	.566938				
49 RESPIRATORY THERAPY	.328437				
50 PHYSICAL THERAPY	1.378631				112,586
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.797083				
56 DRUGS CHARGED TO PATIENTS	2.004086				
62 OUTPAT SERVICE COST CNTRS					
62 OBSERVATION BEDS (NON-DISTINCT PART)					
101 SUBTOTAL					112,586
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					112,586

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: | PERIOD: | PREPARED 11/13/2008
 | 26-3303 | FROM 7/ 1/2007 | WORKSHEET D
 | COMPONENT NO: | TO 6/30/2008 | PART V
 | 26-3303 | |

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
	5.01	5.02	5.03	6	7
(A) ANCILLARY SRVC COST CNTRS					
41 RADIOLOGY-DIAGNOSTIC					
44 LABORATORY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56 DRUGS CHARGED TO PATIENTS					
62 OUTPAT SERVICE COST CNTRS					
62 OBSERVATION BEDS (NON-DISTINCT PART)					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
104 PROGRAM ONLY CHARGES					
104 NET CHARGES					

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: | PERIOD: | PREPARED 11/13/2008
 | 26-3303 | FROM 7/ 1/2007 | WORKSHEET D
 | COMPONENT NO: | TO 6/30/2008 | PART V
 | 26-3303 | |

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
	8	9	9.01	9.02	9.03
(A) ANCILLARY SRVC COST CNTRS					
41 RADIOLOGY-DIAGNOSTIC					
44 LABORATORY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY		155,215			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56 DRUGS CHARGED TO PATIENTS					
62 OUTPAT SERVICE COST CNTRS					
62 OBSERVATION BEDS (NON-DISTINCT PART)					
101 SUBTOTAL		155,215			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
104 PROGRAM ONLY CHARGES					
NET CHARGES		155,215			

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 11/13/2008
26-3303	FROM 7/ 1/2007	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2008	PART I
26-3303		

TITLE XVIII PART A

HOSPITAL

TEFRA

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	9,291
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	9,291
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	9,291
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)	80
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	10,180,241
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	10,180,241

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	16,723,800
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	16,723,800
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.608728
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,800.00
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	10,180,241

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 11/13/2008
26-3303	FROM 7/1/2007	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2008	PART II
26-3303		

TITLE XVIII PART A HOSPITAL TEFRA

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	1,095.71
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	87,657
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	87,657

	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				
49	TOTAL PROGRAM INPATIENT COSTS				
					40,560
					128,217

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	15,654
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	3,006
52	TOTAL PROGRAM EXCLUDABLE COST	18,660
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	109,557

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES	1
55	TARGET AMOUNT PER DISCHARGE	27,661.22
56	TARGET AMOUNT	27,661
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	-81,896
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	2,766
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT	49,087
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 11/13/2008
26-3303	FROM 7/ 1/2007	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2008	PART III
26-3303		

TITLE XVIII PART A HOSPITAL TEFRA

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,095.71
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	10,180,241			
87	NEW CAPITAL-RELATED COST	1,817,959	.178577		
88	NON PHYSICIAN ANESTHETIST	10,180,241			
89	MEDICAL EDUCATION	10,180,241			
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO: 26-3303
 COMPONENT NO: 26-3303
 PERIOD: FROM 7/1/2007 TO 6/30/2008
 PREPARED 11/13/2008
 WORKSHEET D-1
 PART II

TITLE XIX - I/P HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 1,095.71
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 4,946,035
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 4,946,035

	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)					
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
44 INTENSIVE CARE UNIT					
45 CORONARY CARE UNIT					
46 BURN INTENSIVE CARE UNIT					
47 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					1
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					3,093,022
49 TOTAL PROGRAM INPATIENT COSTS					8,039,057

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 11/13/2008
26-3303	FROM 7/ 1/2007	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2008	PART III
26-3303		

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	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,095.71
85	OBSERVATION BED COST	

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

PROVIDER NO: 26-3303
 COMPONENT NO: 26-3303
 PERIOD: FROM 7/1/2007 TO 6/30/2008
 PREPARED 11/13/2008
 WORKSHEET D-4

TITLE XVIII, PART A HOSPITAL

TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS ANCILLARY SRVC COST CNTRS		144,000	
41	RADIOLOGY-DIAGNOSTIC	1.002622		
44	LABORATORY	.566938	1,887	1,070
49	RESPIRATORY THERAPY	.328437		
50	PHYSICAL THERAPY	1.378631	3,843	5,298
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.797083	13,178	10,504
56	DRUGS CHARGED TO PATIENTS	2.004086	11,820	23,688
62	OUTPAT SERVICE COST CNTRS OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS			
101	TOTAL		30,728	40,560
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		30,728	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

PROVIDER NO: 26-3303
 COMPONENT NO: 26-3303
 PERIOD: FROM 7/1/2007 TO 6/30/2008
 PREPARED 11/13/2008
 WORKSHEET D-4

WKST A LINE NO.	TITLE XIX COST CENTER DESCRIPTION	HOSPITAL	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS ANCILLARY SRVC COST CNTRS			8,125,200	
41	RADIOLOGY-DIAGNOSTIC		1.002622	61,677	61,839
44	LABORATORY		.566938	109,856	62,282
49	RESPIRATORY THERAPY		.328437	2,610,592	857,415
50	PHYSICAL THERAPY		1.378631	470,126	648,130
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		.797083	446,911	356,225
56	DRUGS CHARGED TO PATIENTS		2.004086	552,437	1,107,131
62	OUTPAT SERVICE COST CNTRS OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS				
101	TOTAL			4,251,599	3,093,022
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES				
103	NET CHARGES			4,251,599	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

PROVIDER NO: 26-3303
 COMPONENT NO: 26-3303
 PERIOD: FROM 7/1/2007 TO 6/30/2008
 PREPARED 11/13/2008
 WORKSHEET E-1

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		PART B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		38,118		
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		
ADJUSTMENTS TO PROGRAM		.51		
ADJUSTMENTS TO PROGRAM		.52		
ADJUSTMENTS TO PROGRAM		.53		
ADJUSTMENTS TO PROGRAM		.54		
SUBTOTAL		.99		
4 TOTAL INTERIM PAYMENTS			NONE	NONE
			38,118	
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		
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			NONE	NONE
SETTLEMENT TO PROVIDER		.01		
SETTLEMENT TO PROGRAM		.02		
7 TOTAL MEDICARE PROGRAM LIABILITY				

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

PROVIDER NO: 26-3303
 PERIOD: FROM 7/1/2007 TO 6/30/2008
 COMPONENT NO: 26-3303
 PREPARED 11/13/2008
 WORKSHEET E-3
 PART I

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

1	INPATIENT HOSPITAL SERVICES (SEE INSTRUCTIONS)	49,087
1.01	HOSPITAL SPECIFIC AMOUNT (SEE INSTRUCTIONS)	
1.02	ENTER FROM THE PS&R, THE IRF PPS PAYMENT	
1.03	MEDICAID SSI RATIO (IRF PPS ONLY) (SEE INSTR.)	
1.04	INPATIENT REHABILITATION FACILITY LIP PAYMENTS (SEE INSTRUCTIONS)	
1.05	OUTLIER PAYMENTS	
1.06	TOTAL PPS PAYMENTS (SUM OF LINES 1.01, (1.02, 1.04 FOR COLUMNS 1 & 1.01), 1.05 AND 1.42)	
1.07	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)	
INPATIENT PSYCHIATRIC FACILITY (IPF)		
1.08	NET FEDERAL IPF PPS PAYMENTS (EXCLUDING OUTLIER, ECT, STOP-LOSS, AND MEDICAL EDUCATION PAYMENTS)	
1.09	NET IPF PPS OUTLIER PAYMENTS	
1.10	NET IPF PPS ECT PAYMENTS	
1.11	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR LATEST COST REPORT FILED PRIOR TO NOVEMBER 15, 2004 (SEE INSTRUCTIONS)	
1.12	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)	
1.13	CURRENT YEARS UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.14	CURRENT YEARS UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.15	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.16	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	
1.17	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{((1 + (LINE 1.15/1.16)) \text{ RAISED TO THE POWER OF } .5150 - 1)\}$.	
1.18	MEDICAL EDUCATION ADJUSTMENT (LINE 1.08 MULTIPLIED BY LINE 1.17).	
1.19	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1.08, 1.09, 1.10 AND 1.18)	
1.20	STOP LOSS PAYMENT FLOOR (LINE 1 x 70%)	
1.21	ADJUSTED NET PAYMENT FLOOR (LINE 1.20 x THE APPROPRIATE FEDERAL BLEND PERCENTAGE)	
1.22	STOP LOSS ADJUSTMENT (IF LINE 1.21 IS GREATER THAN LINE 1.19 ENTER THE AMOUNT ON LINE 1.21 LESS LINE 1.19 OTHERWISE ENTER -0-)	
1.23	TOTAL IPF PPS PAYMENTS (SUM OF LINES 1.01, 1.19 AND 1.22)	
INPATIENT REHABILITATION FACILITY (IRF)		
1.35	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR COST REPORT PERIODS ENDING ON/OR PRIOR TO NOVEMBER 15, 2004. (SEE INST.)	
1.36	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)	
1.37	CURRENT YEAR'S UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.38	CURRENT YEAR'S UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.39	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.40	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	
1.41	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{((1 + (LINE 1.39/1.40)) \text{ RAISED TO THE POWER OF } .9012 - 1)\}$.	
1.42	MEDICAL EDUCATION ADJUSTMENT (LINE 1.02 MULTIPLIED BY LINE 1.41).	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL (SEE INSTRUCTIONS)	49,087
5	PRIMARY PAYER PAYMENTS	
6	SUBTOTAL	49,087
7	DEDUCTIBLES	
8	SUBTOTAL	49,087
9	COINSURANCE	
10	SUBTOTAL	49,087
11	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROF SERV)	
11.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
11.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
12	SUBTOTAL	49,087
13	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
13.01	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)	
14	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
15	OTHER ADJUSTMENTS (SPECIFY)	
15.99	OUTLIER RECONCILIATION ADJUSTMENT	
16	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 11/13/2008
26-3303	FROM 7/ 1/2007	WORKSHEET E-3
COMPONENT NO:	TO 6/30/2008	PART I
26-3303		

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

17	RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	49,087
18	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
19	INTERIM PAYMENTS	38,118
19.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
20	BALANCE DUE PROVIDER/PROGRAM	10,969
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, SECTION 115.2.	

- FI ONLY -----
- 50 ENTER THE ORIGINAL OUTLIER AMOUNT FROM E-3, I LN 1.05 (IRF) OR 1.09 (IPF).
 - 51 ENTER THE OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)
 - 52 ENTER THE INTEREST RATE USED TO CALCULATE THE TIME VALUE OF MONEY. (SEE INSTRUCTIONS).
 - 53 ENTER THE TIME VALUE OF MONEY.

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 11/13/2008
26-3303	FROM 7/1/2007	WORKSHEET E-3
COMPONENT NO:	TO 6/30/2008	PART III
-		

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

	TITLE XIX	HOSPITAL	OTHER TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
	COMPUTATION OF NET COST OF COVERED SERVICE			
1	INPATIENT HOSPITAL/SNF/NF SERVICES			
2	MEDICAL AND OTHER SERVICES			
3	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			
4	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)			
5	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			
6	SUBTOTAL			
7	INPATIENT PRIMARY PAYER PAYMENTS			
8	OUTPATIENT PRIMARY PAYER PAYMENTS			
9	SUBTOTAL			
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
10	ROUTINE SERVICE CHARGES			
11	ANCILLARY SERVICE CHARGES			
12	INTERNS AND RESIDENTS SERVICE CHARGES			
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE			
14	TEACHING PHYSICIANS			
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION			
16	TOTAL REASONABLE CHARGES			
	CUSTOMARY CHARGES			
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			
19	RATIO OF LINE 17 TO LINE 18			
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)			
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
23	COST OF COVERED SERVICES			
	PROSPECTIVE PAYMENT AMOUNT			
24	OTHER THAN OUTLIER PAYMENTS			
25	OUTLIER PAYMENTS			
26	PROGRAM CAPITAL PAYMENTS			
27	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS			
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS			
30	SUBTOTAL			
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)			
32	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE XVIII ENTER AMOUNT FROM LINE 30			
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34	EXCESS OF REASONABLE COST			
35	SUBTOTAL			
36	COINSURANCE			
37	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19			
38	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			
38.01	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING BEFORE 10/01/05 (SEE INSTRUCTIONS)			
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)			
39	UTILIZATION REVIEW			
40	SUBTOTAL (SEE INSTRUCTIONS)			
41	INPATIENT ROUTINE SERVICE COST			
42	MEDICARE INPATIENT ROUTINE CHARGES			
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT OF PART A SERVICES			
45	RATIO OF LINE 43 TO 44			
46	TOTAL CUSTOMARY CHARGES			
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			
50	OTHER ADJUSTMENTS (SPECIFY)			
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			
52	SUBTOTAL			
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER			
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
57	INTERIM PAYMENTS			
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			
58	BALANCE DUE PROVIDER/PROGRAM			
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)			

CALCULATION OF REIMBURSEMENT SETTLEMENT

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

	IN LIEU OF FORM CMS-2552-96-E-3 (5/2008)				
	PROVIDER NO:		PERIOD:		PREPARED 11/13/2008
	26-3303		FROM 7/ 1/2007		WORKSHEET E-3
	COMPONENT NO:		TO 6/30/2008		PART III
	-				

TITLE XIX

HOSPITAL

OTHER
TITLE V OR
TITLE XIX
1

TITLE XVIII
SNF PPS
2

IN ACCORDANCE WITH CMS PUB. 15-11, SECTION 115.2.

BALANCE SHEET

		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	7,743,755			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	3,943,008			
5	OTHER RECEIVABLES	242,163			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-558			
7	INVENTORY				
8	PREPAID EXPENSES	339,100			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	12,267,468			
FIXED ASSETS					
12	LAND	2,359,177			
12.01	LAND IMPROVEMENTS				
13	LESS ACCUMULATED DEPRECIATION				
13.01	BUILDINGS	19,499,093			
14	LESS ACCUMULATED DEPRECIATION	-1,717,899			
14.01	LEASEHOLD IMPROVEMENTS				
15	LESS ACCUMULATED DEPRECIATION				
15.01	FIXED EQUIPMENT				
16	LESS ACCUMULATED DEPRECIATION				
16.01	AUTOMOBILES AND TRUCKS				
17	LESS ACCUMULATED DEPRECIATION				
17.01	MAJOR MOVABLE EQUIPMENT	2,433,832			
18	LESS ACCUMULATED DEPRECIATION	-988,951			
18.01	MINOR EQUIPMENT DEPRECIABLE				
19	LESS ACCUMULATED DEPRECIATION				
19.01	MINOR EQUIPMENT-NONDEPRECIABLE				
20	TOTAL FIXED ASSETS	21,585,252			
21	OTHER ASSETS				
22	INVESTMENTS	9,361,867			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	610,825			
26	TOTAL OTHER ASSETS	9,972,692			
27	TOTAL ASSETS	43,825,412			

STATEMENT OF CHANGES IN FUND BALANCES

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	FUND BALANCE AT BEGINNING OF PERIOD		15,126,665		
2	NET INCOME (LOSS)		5,767,795		
3	TOTAL		20,894,460		
4	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5	ADDITIONS (CREDIT ADJUSTM				
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL		20,894,460		
12	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13	NET ASSETS RELEASED FROM	48,507			
14					
15					
16					
17					
18	TOTAL DEDUCTIONS		48,507		
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		20,845,953		

		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	NET ASSETS RELEASED FROM				
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET				

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

PROVIDER NO: 26-3303
 PERIOD: FROM 7/1/2007 TO 6/30/2008
 PREPARED 11/13/2008
 WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	16,723,800		16,723,800
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	16,723,800		16,723,800
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	16,723,800		16,723,800
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	16,723,800		16,723,800
17 00 ANCILLARY SERVICES	7,425,783		7,425,783
18 00 OUTPATIENT SERVICES		687,796	687,796
24 00 PHYSICIAN SERVICES	160,076		160,076
25 00 TOTAL PATIENT REVENUES	24,309,659	687,796	24,997,455

PART II - OPERATING EXPENSES

26 00 OPERATING EXPENSES		17,673,867	
ADD (SPECIFY)			
27 00 BAD DEBT EXPENSE	94,235		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		94,235	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		17,768,102	

STATEMENT OF REVENUES AND EXPENSES

PROVIDER NO: 26-3303
 PERIOD: FROM 7/1/2007 TO 6/30/2008
 PREPARED 11/13/2008
 WORKSHEET G-3

DESCRIPTION

1	TOTAL PATIENT REVENUES	24,997,455
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	3,449,330
3	NET PATIENT REVENUES	21,548,125
4	LESS: TOTAL OPERATING EXPENSES	17,768,102
5	NET INCOME FROM SERVICE TO PATIENTS	3,780,023
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	849,515
7	INCOME FROM INVESTMENTS	956,914
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	6,120
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	MISCELLANEOUS INCOME	126,716
24.01	NET ASSETS RELEASED FROM RESTRICTION	48,507
25	TOTAL OTHER INCOME	1,987,772
26	TOTAL	5,767,795
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	5,767,795