

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).

WORKSHEET S  
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	15-4041	I	FROM 1/ 1/2009	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 12/31/2009	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
			I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/10/2010 TIME 8:48

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:

BHC MEADOWS HOSPITAL 15-4041

FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2009 AND ENDING 12/31/2009 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION  
DATE: 5/10/2010 TIME 8:48

xMvnlr324Ryk.OzPAV9eE0CkiNioc0  
ApipA0m29I58yXupeF69srM9YIMrHP  
ldgK0CapsQ0YbPB0

PI ENCRYPTION INFORMATION  
DATE: 5/10/2010 TIME 8:48

ertMLqwfCG66LHcsONWpIT5NEsSw0  
yh79Z0EACs6M7ZDUNPHmsD6efF.MS6  
7GoK3xMQ090mCmqw

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	-123,789		8,484		0	71,743	
100	TOTAL	-123,789		8,484		0	71,743	

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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

WORKSHEET S  
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	15-4041	I	FROM 1/ 1/2009	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 12/31/2009	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
			I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/10/2010 TIME 9:01

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:

BHC MEADOWS HOSPITAL 15-4041  
FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2009 AND ENDING 12/31/2009 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	-123,789		8,484		0 71,743
100	TOTAL	-123,789		8,484		0 71,743

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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

FORM APPROVED  
OMB NO. 0938-0050

WORKSHEET S  
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	15-4041	I	FROM 1/ 1/2009	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 12/31/2009	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
						--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/10/2010 TIME 9:03

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:

BHC MEADOWS HOSPITAL 15-4041  
FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2009 AND ENDING 12/31/2009 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	-123,789		8,484		0	71,743	
100	TOTAL	-123,789		8,484		0	71,743	

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

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

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2009 TO: 12/31/2009  
 18 TYPE OF CONTROL 1 2  
 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? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. N
- 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
- 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 1 N Y 14020
- 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 \$5105 OR MIPPA \$147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO. N
- 21.07 DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA \$147? ENTER "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N
- 21.08 WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEEDING COST REPORTING PERIOD? ENTER IN COLUMN 2, "Y" FOR YES OR "N" FOR NO. N
- 22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N
- 23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N
- 23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. / / / /
- 23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY) / /
- 24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). / /

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010
I 15-4041 I FROM 1/ 1/2009 I WORKSHEET S-2
I I TO 12/31/2009 I

- 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 2 3 4
0 0.0000 0.0000
28.02 ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY 0.00 0
A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR) % Y/N
28.03 STAFFING 0.00%
28.04 RECRUITMENT 0.00%
28.05 RETENTION 0.00%
28.06 TRAINING 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) N
30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000). N
30.04 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II N
31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). 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)? N
35.03 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N
35.04 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N

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

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

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

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

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

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

	DATE 0	Y OR N 1	LIMIT		Y OR N		FEES 4
			2	3	3	4	
		N	0.00				0
			0.00				0
			0.00				0
			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).
- 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
- 60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN  
 THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y"  
 FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN  
 ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(c)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF  
 COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST  
 REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT  
 ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC). 0

MULTICAMPUS

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

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

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00

SETTLEMENT DATA

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

HOSPITAL AND HOSPITAL HEALTH CARE  
COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
I 15-4041 I FROM 1/ 1/2009 I WORKSHEET S-3  
I I TO 12/31/2009 I PART I

COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH N/A	TITLE V	I/P DAYS / TITLE XVIII	O/P VISITS / NOT LTCH N/A	TRIPS TOTAL TITLE XIX
1 ADULTS & PEDIATRICS	38	13,870	2.01	3	432	482	556
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	38	13,870			432	482	556
6 INTENSIVE CARE UNIT							
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL	38	13,870			432	482	556
13 RPCH VISITS							
17 OTHER LONG TERM CARE	30	10,950					
25 TOTAL	68						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	TITLE XIX ADMITTED	I/P DAYS / OBSERVATION BEDS NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	TRIPS / TOTAL OBSERVATION BEDS ADMITTED	TRIPS / TOTAL OBSERVATION BEDS NOT ADMITTED	INTERNS & RES. FTES / TOTAL	RES. FTES / LESS I&R REPL NON-PHYS ANES
1 ADULTS & PEDIATRICS	5.01	5.02	6	6.01	6.02	7	8
2 HMO			7,016				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS			7,016				
6 INTENSIVE CARE UNIT							
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL			7,016				
13 RPCH VISITS							
17 OTHER LONG TERM CARE			10,080				
25 TOTAL							
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	I & R FTES NET	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	DISCHARGES TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2 HMO				57	74	76	1,142
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		72.22		57	74	76	1,142
13 RPCH VISITS							
17 OTHER LONG TERM CARE		32.69					70
25 TOTAL		104.91					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSESI PROVIDER NO:  
I 15-4041  
II PERIOD:  
I FROM 1/ 1/2009  
I TO 12/31/2009 II PREPARED 5/10/2010  
I WORKSHEET A  
I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		286,817	286,817	11,400	298,217
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		12,150	12,150	74,406	86,556
5	0500 EMPLOYEE BENEFITS	46,643	402,002	448,645	-149	448,496
6	0600 ADMINISTRATIVE & GENERAL	1,511,025	1,171,779	2,682,804	-104,054	2,578,750
7	0700 MAINTENANCE & REPAIRS	76,249	192,981	269,230	-1,129	268,101
9	0900 LAUNDRY & LINEN SERVICE		27,890	27,890		27,890
10	1000 HOUSEKEEPING	52,471	22,092	74,563		74,563
11	1100 DIETARY	134,671	161,763	296,434		296,434
12	1200 CAFETERIA					
14	1400 NURSING ADMINISTRATION	200,589	23,541	224,130	-166	223,964
14.01	1401 MEDICAL ADMINISTRATION					
17	1700 MEDICAL RECORDS & LIBRARY	58,266	74,789	133,055		133,055
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	1,558,987	159,152	1,718,139	-139,550	1,578,589
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	981,310	124,865	1,106,175	72,845	1,179,020
	ANCILLARY SRVC COST CNTRS					
44	4400 LABORATORY		27,633	27,633		27,633
56	5600 DRUGS CHARGED TO PATIENTS		176,941	176,941	-2,854	174,087
59	3550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		29,050	29,050		29,050
	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	4,620,211	2,893,445	7,513,656	-89,251	7,424,405
	NONREIMBURS COST CENTERS					
100.01	7951 COMMUNITY RELATIONS				89,251	89,251
100.02	7952 OUTPATIENT MEALS					
100.03	7953 CLINICAL TRIALS					
101	TOTAL	4,620,211	2,893,445	7,513,656	-0-	7,513,656

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSESI PROVIDER NO:  
I 15-4041  
II PERIOD:  
I FROM 1/ 1/2009  
I TO 12/31/2009  
II PREPARED 5/10/2010  
I WORKSHEET A  
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	-10,525	287,692
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	42,734	129,290
5	0500 EMPLOYEE BENEFITS	-41,465	407,031
6	0600 ADMINISTRATIVE & GENERAL	-115,129	2,463,621
7	0700 MAINTENANCE & REPAIRS		268,101
9	0900 LAUNDRY & LINEN SERVICE		27,890
10	1000 HOUSEKEEPING		74,563
11	1100 DIETARY	-13,376	283,058
12	1200 CAFETERIA		
14	1400 NURSING ADMINISTRATION		223,964
14.01	1401 MEDICAL ADMINISTRATION		
17	1700 MEDICAL RECORDS & LIBRARY	-4,560	128,495
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-10,740	1,567,849
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	-888	1,178,132
	ANCILLARY SRVC COST CNTRS		
44	4400 LABORATORY		27,633
56	5600 DRUGS CHARGED TO PATIENTS		174,087
59	3550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		29,050
	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	-153,949	7,270,456
	NONREIMBURS COST CENTERS		
100.01	7951 COMMUNITY RELATIONS		89,251
100.02	7952 OUTPATIENT MEALS		
100.03	7953 CLINICAL TRIALS		
101	TOTAL	-153,949	7,359,707

## COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I NOT A CMS WORKSHEET  
 I I TO 12/31/2009 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

RECLASSIFICATIONS

PROVIDER NO: 154041	PERIOD: FROM 1/ 1/2009 TO 12/31/2009	PREPARED 5/10/2010 WORKSHEET A-6
------------------------	--	-------------------------------------

EXPLANATION OF RECLASSIFICATION	CODE (1) COST CENTER	INCREASE			
		LINE NO	SALARY	OTHER	
	1	2	3	4	5
1 COMMUNITY RELATIONS	A	COMMUNITY RELATIONS	100.01	53,584	35,667
2 LEASE/RENT	B	NEW CAP REL COSTS-BLDG & FIXT	3		11,400
3		NEW CAP REL COSTS-MVBLE EQUIP	4		74,406
4					
5					
6					
7					
8 ACTIVITY THERAPY RECLASS	E	OTHER LONG TERM CARE	36	63,683	6,754
9 PHARMACY RECLASS	F	OTHER LONG TERM CARE	36		2,854
10 DIRECTOR OF CLINICAL SERVICES	G	OTHER LONG TERM CARE	36	16,023	1,220
11		ADMINISTRATIVE & GENERAL	6	48,069	3,661
36 TOTAL RECLASSIFICATIONS				181,359	135,962

(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: 154041	PERIOD: FROM 1/ 1/2009 TO 12/31/2009	PREPARED 5/10/2010 WORKSHEET A-6
------------------------	--	-------------------------------------

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE			A-7 REF 10
			LINE NO	SALARY	OTHER	
	1	6	7	8	9	
1 COMMUNITY RELATIONS	A	ADMINISTRATIVE & GENERAL	6	53,584	35,667	
2 LEASE/RENT	B	ADMINISTRATIVE & GENERAL	6		66,533	10
3		MAINTENANCE & REPAIRS	7		1,129	10
4		NURSING ADMINISTRATION	14		166	
5		ADULTS & PEDIATRICS	25		140	
6		OTHER LONG TERM CARE	36		17,689	
7		EMPLOYEE BENEFITS	5		149	
8 ACTIVITY THERAPY RECLASS	E	ADULTS & PEDIATRICS	25	63,683	6,754	
9 PHARMACY RECLASS	F	DRUGS CHARGED TO PATIENTS	56		2,854	
10 DIRECTOR OF CLINICAL SERVICES	G	ADULTS & PEDIATRICS	25	64,092	4,881	
11						
36 TOTAL RECLASSIFICATIONS				181,359	135,962	

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
154041	FROM 1/ 1/2009	5/10/2010
	TO 12/31/2009	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: A  
EXPLANATION : COMMUNITY RELATIONS

INCREASE			DECREASE		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	COMMUNITY RELATIONS	89,251	ADMINISTRATIVE & GENERAL	6	89,251
TOTAL RECLASSIFICATIONS FOR CODE A		89,251			

RECLASS CODE: B  
EXPLANATION : LEASE/RENT

INCREASE			DECREASE		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	11,400	ADMINISTRATIVE & GENERAL	6	66,533
2.00	NEW CAP REL COSTS-MVBLE EQUIP	74,406	MAINTENANCE & REPAIRS	7	1,129
3.00		0	NURSING ADMINISTRATION	14	166
4.00		0	ADULTS & PEDIATRICS	25	140
5.00		0	OTHER LONG TERM CARE	36	17,689
6.00		0	EMPLOYEE BENEFITS	5	149
TOTAL RECLASSIFICATIONS FOR CODE B		85,806			

RECLASS CODE: E  
EXPLANATION : ACTIVITY THERAPY RECLASS

INCREASE			DECREASE		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OTHER LONG TERM CARE	70,437	ADULTS & PEDIATRICS	25	70,437
TOTAL RECLASSIFICATIONS FOR CODE E		70,437			

RECLASS CODE: F  
EXPLANATION : PHARMACY RECLASS

INCREASE			DECREASE		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OTHER LONG TERM CARE	2,854	DRUGS CHARGED TO PATIENTS	56	2,854
TOTAL RECLASSIFICATIONS FOR CODE F		2,854			

RECLASS CODE: G  
EXPLANATION : DIRECTOR OF CLINICAL SERVICES

INCREASE			DECREASE		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OTHER LONG TERM CARE	17,243	ADULTS & PEDIATRICS	25	68,973
2.00	ADMINISTRATIVE & GENERAL	51,730			0
TOTAL RECLASSIFICATIONS FOR CODE G		68,973			

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	199,566	11,400		19,820	56,906		287,692
4	NEW CAP REL COSTS-MV	54,051	74,406		833			129,290
5	TOTAL	253,617	85,806		20,653	56,906		416,982

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	210,091			19,820	56,906		286,817
4	NEW CAP REL COSTS-MV	11,317			833			12,150
5	TOTAL	221,408			20,653	56,906		298,967

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: I PERIOD:  
I 15-4041 I FROM 1/ 1/2009 I PREPARED 5/10/2010  
I I TO 12/31/2009 I WORKSHEET A-8

I PERIOD: I PREPARED 5/10/2010  
I FROM 1/ 1/2009 I WORKSHEET A-8  
I TO 12/31/2009 I

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		LINE NO	WKST. A-7 REF. 5
			COST CENTER	COST CENTER		
	1	2	3	4	4	5
1			**COST CENTER DELETED**		1	
2			**COST CENTER DELETED**		2	
3			NEW CAP REL COSTS-BLDG &		3	
4			NEW CAP REL COSTS-MVBLE E		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						
31						
32						
33						
34						
35						
36						
37						
38						
39						
39.01						
40						
41						
42						
43						
44						
45						
46						
47						
48						
49						
49.01						
49.06						
49.07						
49.08						
50						
TOTAL (SUM OF LINES 1 THRU 49)						

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

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to worksheet A-7

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	6	ADMINISTRATIVE & GENERAL	HOME OFFICE COSTS	350,810	302,736	48,074
2						
3						
4						
4.03						
4.04						
4.06						
4.08						
4.10						
5		TOTALS		350,810	302,736	48,074

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO:  
I 15-4041  
I

I PERIOD: I PREPARED 5/10/2010  
I FROM 1/ 1/2009 I WORKSHEET A-8-2  
I TO 12/31/2009 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	AGGREGATE	7,000	7,000					
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	7,000	7,000					



COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I NOT A CMS WORKSHEET  
 I I TO 12/31/2009 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION			
	GENERAL SERVICE COST					
3	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE	FOO	TAGE	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	1	SQUARE	FOO	TAGE	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS		SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	-3	ACCUM.	COST		NOT ENTERED
7	MAINTENANCE & REPAIRS	1	SQUARE	FOO	TAGE	ENTERED
9	LAUNDRY & LINEN SERVICE	5	DIRECT	COS	T	ENTERED
10	HOUSEKEEPING	1	SQUARE	FOO	TAGE	ENTERED
11	DIETARY	7	MEALS	SERV	ED	ENTERED
12	CAFETERIA	8	FTES			ENTERED
14	NURSING ADMINISTRATION	9	NURSING	AD	MIN H	ENTERED
14.01	MEDICAL ADMINISTRATION	10	MEDICAL	AD	MIN T	ENTERED
17	MEDICAL RECORDS & LIBRARY	C	GROSS		CHARGES	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET B  
 I I TO 12/31/2009 I PART I

COST CENTER DESCRIPTION		NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTs-BLDG &	NEW CAP REL C OSTs-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS
		0	3	4	5	5a.00	6	7
GENERAL SERVICE COST CNTR								
003	NEW CAP REL COSTS-BLDG &	287,692	287,692					
004	NEW CAP REL COSTS-MVBLE E	129,290		129,290				
005	EMPLOYEE BENEFITS	407,031	1,713	770	409,514			
006	ADMINISTRATIVE & GENERAL	2,463,621	41,433	18,620	134,804	2,658,478	2,658,478	
007	MAINTENANCE & REPAIRS	268,101	7,713	3,466	6,827	286,107	161,790	447,897
009	LAUNDRY & LINEN SERVICE	27,890	6,256	2,812		36,958	20,899	11,832
010	HOUSEKEEPING	74,563	6,332	2,846	4,698	88,439	50,011	11,975
011	DIETARY	283,058	26,860	12,071	12,058	334,047	188,899	50,797
012	CAFETERIA							
014	NURSING ADMINISTRATION	223,964	2,694	1,211	17,961	245,830	139,013	5,095
014	01 MEDICAL ADMINISTRATION		7,381	3,317		10,698	6,050	13,959
017	MEDICAL RECORDS & LIBRARY	128,495	3,962	1,781	5,217	139,455	78,860	7,493
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	1,567,849	95,086	42,731	128,149	1,833,815	1,036,994	179,825
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	1,178,132	87,447	39,299	95,002	1,399,880	791,613	165,380
	ANCILLARY SRVC COST CNTRS							
044	LABORATORY	27,633	558	251		28,442	16,084	1,056
056	DRUGS CHARGED TO PATIENTS	174,087				174,087	98,444	
059	PSYCHIATRIC/PSYCHOLOGICAL	29,050				29,050	16,427	
	OUTPAT SERVICE COST CNTRS							
060	CLINIC							
061	EMERGENCY							
062	OBSERVATION BEDS (NON-DIS							
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	7,270,456	287,435	129,175	404,716	7,265,286	2,605,084	447,412
	NONREIMBURS COST CENTERS							
100	01 COMMUNITY RELATIONS	89,251	257	115	4,798	94,421	53,394	485
100	02 OUTPATIENT MEALS							
100	03 CLINICAL TRIALS							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	7,359,707	287,692	129,290	409,514	7,359,707	2,658,478	447,897

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET B  
 I I TO 12/31/2009 I PART I

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL ADMINISTRATION	MEDICAL RECORDS & LIBRARY
	9	10	11	12	14	14.01	17
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
009 MAINTENANCE & REPAIRS							
010 LAUNDRY & LINEN SERVICE	69,689						
011 HOUSEKEEPING		150,425					
012 DIETARY		18,018	591,761				
012 CAFETERIA			68,052	68,052			
014 NURSING ADMINISTRATION		1,807		2,708	394,453		
014 01 MEDICAL ADMINISTRATION		4,951				35,658	
017 MEDICAL RECORDS & LIBRARY		2,658		1,868			230,334
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	29,670	63,784	214,929	30,156	190,424	35,658	157,361
027 INTENSIVE CARE UNIT							
028 CORONARY CARE UNIT							
029 BURN INTENSIVE CARE UNIT							
033 SURGICAL INTENSIVE CARE U							
036 NURSERY							
036 OTHER LONG TERM CARE	40,019	58,660	308,780	32,312	204,029		67,166
044 ANCILLARY SRVC COST CNTRS							
056 LABORATORY		375					1,487
059 DRUGS CHARGED TO PATIENTS							3,468
060 PSYCHIATRIC/PSYCHOLOGICAL							852
061 OUTPAT SERVICE COST CNTRS							
062 CLINIC							
062 EMERGENCY							
095 OBSERVATION BEDS (NON-DIS							
095 SPEC PURPOSE COST CENTERS							
100 SUBTOTALS	69,689	150,253	591,761	67,044	394,453	35,658	230,334
100 01 NONREIMBURS COST CENTERS							
100 01 COMMUNITY RELATIONS		172		1,008			
100 02 OUTPATIENT MEALS							
100 03 CLINICAL TRIALS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	69,689	150,425	591,761	68,052	394,453	35,658	230,334

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET B  
 I I TO 12/31/2009 I PART I

COST CENTER DESCRIPTION	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	25	26	27
003 GENERAL SERVICE COST CNTR			
004 NEW CAP REL COSTS-BLDG &			
005 NEW CAP REL COSTS-MVBLE E			
006 EMPLOYEE BENEFITS			
007 ADMINISTRATIVE & GENERAL			
009 MAINTENANCE & REPAIRS			
010 LAUNDRY & LINEN SERVICE			
011 HOUSEKEEPING			
012 DIETARY			
014 CAFETERIA			
014 NURSING ADMINISTRATION			
017 01 MEDICAL ADMINISTRATION			
017 MEDICAL RECORDS & LIBRARY			
025 INPAT ROUTINE SRVC CNTRS			
026 ADULTS & PEDIATRICS	3,772,616		3,772,616
027 INTENSIVE CARE UNIT			
028 CORONARY CARE UNIT			
029 BURN INTENSIVE CARE UNIT			
033 SURGICAL INTENSIVE CARE U			
036 NURSERY			
036 OTHER LONG TERM CARE	3,067,839		3,067,839
044 ANCILLARY SRVC COST CNTRS			
044 LABORATORY	47,444		47,444
056 DRUGS CHARGED TO PATIENTS	275,999		275,999
059 PSYCHIATRIC/PSYCHOLOGICAL	46,329		46,329
060 OUTPAT SERVICE COST CNTRS			
061 CLINIC			
062 EMERGENCY			
062 OBSERVATION BEDS (NON-DIS			
095 SPEC PURPOSE COST CENTERS			
095 SUBTOTALS	7,210,227		7,210,227
100 01 NONREIMBURS COST CENTERS			
100 01 COMMUNITY RELATIONS	149,480		149,480
100 02 OUTPATIENT MEALS			
100 03 CLINICAL TRIALS			
101 CROSS FOOT ADJUSTMENT			
102 NEGATIVE COST CENTER			
103 TOTAL	7,359,707		7,359,707

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET B  
 I I TO 12/31/2009 I PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS	ADMINISTRATIV E & GENERAL	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							
005 EMPLOYEE BENEFITS		1,713	770	2,483	2,483		
006 ADMINISTRATIVE & GENERAL	14,769	41,433	18,620	74,822	818	75,640	
007 MAINTENANCE & REPAIRS		7,713	3,466	11,179	41	4,603	15,823
009 LAUNDRY & LINEN SERVICE		6,256	2,812	9,068		595	418
010 HOUSEKEEPING		6,332	2,846	9,178	28	1,423	423
011 DIETARY		26,860	12,071	38,931	73	5,374	1,795
012 CAFETERIA							
014 NURSING ADMINISTRATION		2,694	1,211	3,905	109	3,955	180
014 01 MEDICAL ADMINISTRATION		7,381	3,317	10,698		172	493
017 03 MEDICAL RECORDS & LIBRARY		3,962	1,781	5,743	32	2,244	265
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS		95,086	42,731	137,817	777	29,506	6,353
027 INTENSIVE CARE UNIT							
028 CORONARY CARE UNIT							
029 BURN INTENSIVE CARE UNIT							
033 SURGICAL INTENSIVE CARE U							
036 NURSERY		87,447	39,299	126,746	576	22,523	5,842
044 OTHER LONG TERM CARE							
056 ANCILLARY SRVC COST CNTRS		558	251	809		458	37
059 LABORATORY						2,801	
060 DRUGS CHARGED TO PATIENTS						467	
061 PSYCHIATRIC/PSYCHOLOGICAL							
062 OUTPAT SERVICE COST CNTRS							
060 CLINIC							
061 EMERGENCY							
062 OBSERVATION BEDS (NON-DIS							
095 SPEC PURPOSE COST CENTERS	14,769	287,435	129,175	431,379	2,454	74,121	15,806
100 01 SUBTOTALS							
100 02 NONREIMBURS COST CENTERS							
100 03 COMMUNITY RELATIONS		257	115	372	29	1,519	17
101 02 OUTPATIENT MEALS							
102 03 CLINICAL TRIALS							
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	14,769	287,692	129,290	431,751	2,483	75,640	15,823

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET B  
 I I TO 12/31/2009 I PART III

COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL ADMIN ISTRATION	ADMIN DS & LIBRARY	MEDICAL RECOR
	9	10	11	12	14	14.01		17
003 GENERAL SERVICE COST CNTR								
004 NEW CAP REL COSTS-BLDG &								
005 NEW CAP REL COSTS-MVBLE E								
006 EMPLOYEE BENEFITS								
007 ADMINISTRATIVE & GENERAL								
009 MAINTENANCE & REPAIRS								
010 LAUNDRY & LINEN SERVICE	10,081							
011 HOUSEKEEPING		11,052						
012 DIETARY		1,324	47,497					
014 CAFETERIA			5,462	5,462				
014 01 NURSING ADMINISTRATION		133		217	8,499			
017 01 MEDICAL ADMINISTRATION		364				11,727		
017 MEDICAL RECORDS & LIBRARY		195		150				8,629
025 INPAT ROUTINE SRVC CNTRS								
026 ADULTS & PEDIATRICS	4,292	4,685	17,251	2,420	4,103	11,727		5,894
027 INTENSIVE CARE UNIT								
028 CORONARY CARE UNIT								
029 BURN INTENSIVE CARE UNIT								
033 SURGICAL INTENSIVE CARE U								
036 NURSERY	5,789	4,310	24,784	2,594	4,396			2,517
044 OTHER LONG TERM CARE								
056 ANCILLARY SRVC COST CNTRS								56
059 LABORATORY		28						130
060 DRUGS CHARGED TO PATIENTS								32
061 PSYCHIATRIC/PSYCHOLOGICAL								
062 OUTPAT SERVICE COST CNTRS								
062 CLINIC								
062 EMERGENCY								
095 OBSERVATION BEDS (NON-DIS								
SPEC PURPOSE COST CENTERS								
095 SUBTOTALS	10,081	11,039	47,497	5,381	8,499	11,727		8,629
100 01 NONREIMBURS COST CENTERS								
100 01 COMMUNITY RELATIONS		13		81				
100 02 OUTPATIENT MEALS								
100 03 CLINICAL TRIALS								
101 CROSS FOOT ADJUSTMENTS								
102 NEGATIVE COST CENTER								
103 TOTAL	10,081	11,052	47,497	5,462	8,499	11,727		8,629

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET B  
 I I TO 12/31/2009 I PART III

COST CENTER DESCRIPTION		SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		25	26	27
003	GENERAL SERVICE COST CNTR			
004	NEW CAP REL COSTS-BLDG &			
005	NEW CAP REL COSTS-MVBLE E			
006	EMPLOYEE BENEFITS			
007	ADMINISTRATIVE & GENERAL			
009	MAINTENANCE & REPAIRS			
010	LAUNDRY & LINEN SERVICE			
011	HOUSEKEEPING			
012	DIETARY			
014	CAFETERIA			
014	NURSING ADMINISTRATION			
017	01 MEDICAL ADMINISTRATION			
	MEDICAL RECORDS & LIBRARY			
	INPAT ROUTINE SRVC CNTRS			
025	ADULTS & PEDIATRICS	224,825		224,825
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	200,077		200,077
	ANCILLARY SRVC COST CNTRS			
044	LABORATORY	1,388		1,388
056	DRUGS CHARGED TO PATIENTS	2,931		2,931
059	PSYCHIATRIC/PSYCHOLOGICAL	499		499
	OUTPAT SERVICE COST CNTRS			
060	CLINIC			
061	EMERGENCY			
062	OBSERVATION BEDS (NON-DIS			
	SPEC PURPOSE COST CENTERS			
095	SUBTOTALS	429,720		429,720
	NONREIMBURS COST CENTERS			
100	01 COMMUNITY RELATIONS	2,031		2,031
100	02 OUTPATIENT MEALS			
100	03 CLINICAL TRIALS			
101	CROSS FOOT ADJUSTMENTS			
102	NEGATIVE COST CENTER			
103	TOTAL	431,751		431,751

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET B-1  
 I I TO 12/31/2009 I

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	RECONCILIATION	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
	OSTS-BLDG & (SQUARE FOOTAGE)	OSTS-MVBLE (SQUARE FOOTAGE)	E FITS (GROSS SALARIES)		E & GENERAL (ACCUM. COST)	REPAIRS (SQUARE FOOTAGE)
	3	4	5	6a.00	6	7
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	38,120					
005 NEW CAP REL COSTS-MVB		38,120				
006 EMPLOYEE BENEFITS	227	227	4,573,568			
007 ADMINISTRATIVE & GENE	5,490	5,490	1,505,510	-2,658,478	4,701,229	
009 MAINTENANCE & REPAIRS	1,022	1,022	76,249		286,107	31,381
010 LAUNDRY & LINEN SERVI	829	829			36,958	829
011 HOUSEKEEPING	839	839	52,471		88,439	839
012 DIETARY	3,559	3,559	134,671		334,047	3,559
014 CAFETERIA						
014 NURSING ADMINISTRATIO	357	357	200,589		245,830	357
014 01 MEDICAL ADMINISTRATIO	978	978			10,698	978
017 MEDICAL RECORDS & LIB	525	525	58,266		139,455	525
025 INPAT ROUTINE SRVC CN						
026 ADULTS & PEDIATRICS	12,599	12,599	1,431,212		1,833,815	12,599
027 INTENSIVE CARE UNIT						
028 CORONARY CARE UNIT						
029 BURN INTENSIVE CARE U						
033 SURGICAL INTENSIVE CA						
036 NURSERY						
044 OTHER LONG TERM CARE	11,587	11,587	1,061,016		1,399,880	11,587
056 ANCILLARY SRVC COST C						
059 LABORATORY	74	74			28,442	74
060 DRUGS CHARGED TO PATI					174,087	
061 PSYCHIATRIC/PSYCHOLOG					29,050	
062 OUTPAT SERVICE COST C						
095 CLINIC						
100 EMERGENCY						
100 01 OBSERVATION BEDS (NON						
100 02 SPEC PURPOSE COST CEN						
100 03 SUBTOTALS	38,086	38,086	4,519,984	-2,658,478	4,606,808	31,347
101 NONREIMBURS COST CENT						
100 01 COMMUNITY RELATIONS	34	34	53,584		94,421	34
100 02 OUTPATIENT MEALS						
100 03 CLINICAL TRIALS						
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	287,692	129,290	409,514		2,658,478	447,897
104 (WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	7.547009		.089539		.565486	
105 (WRKSHT B, PT I)		3.391658				14.272872
105 COST TO BE ALLOCATED						
106 (WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
107 (WRKSHT B, PT II)						
107 COST TO BE ALLOCATED			2,483		75,640	15,823
108 (WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER			.000543		.016089	
108 (WRKSHT B, PT III)						.504222

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET B-1  
 I I TO 12/31/2009 I

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE		DIETARY	CAFETERIA	NURSING ADMINISTRATION		MEDICAL ADMINISTRATION		MEDICAL RECORDS & LIBRARY
		(DIRECT COST)	(SQUARE FOOTAGE)	(MEALS SERVED)	(FTES)	(NURSING)AD	MIN H	(MEDICAL)AD	MIN T	(GROSS CHARGES)
		9	10	11	12	14		14.01		17
003	GENERAL SERVICE COST									
004	NEW CAP REL COSTS-BLD									
005	NEW CAP REL COSTS-MVB									
006	EMPLOYEE BENEFITS									
007	ADMINISTRATIVE & GENE									
009	MAINTENANCE & REPAIRS									
010	LAUNDRY & LINEN SERVI	103,654								
011	HOUSEKEEPING		29,713							
012	DIETARY		3,559	57,896						
014	CAFETERIA			6,658	6,885					
014	NURSING ADMINISTRATIO		357		274	131,456				
014	01 MEDICAL ADMINISTRATIO		978					100		
017	MEDICAL RECORDS & LIB		525		189					19,011,690
025	INPAT ROUTINE SRVC CN									
026	ADULTS & PEDIATRICS	44,130	12,599	21,028	3,051	63,461		100		12,988,331
027	INTENSIVE CARE UNIT									
028	CORONARY CARE UNIT									
029	BURN INTENSIVE CARE U									
033	SURGICAL INTENSIVE CA									
036	NURSERY									
044	OTHER LONG TERM CARE	59,524	11,587	30,210	3,269	67,995				5,544,000
056	ANCILLARY SRVC COST C									
059	LABORATORY		74							122,729
060	DRUGS CHARGED TO PATI									286,280
061	PSYCHIATRIC/PSYCHOLOG									70,350
062	OUTPAT SERVICE COST C									
062	CLINIC									
062	EMERGENCY									
095	OBSERVATION BEDS (NON									
100	SPEC PURPOSE COST CEN									
100	01 SUBTOTALS	103,654	29,679	57,896	6,783	131,456		100		19,011,690
100	NONREIMBURS COST CENT									
100	02 COMMUNITY RELATIONS		34		102					
100	03 OUTPATIENT MEALS									
101	CLINICAL TRIALS									
102	CROSS FOOT ADJUSTMENT									
103	NEGATIVE COST CENTER									
104	COST TO BE ALLOCATED	69,689	150,425	591,761	68,052	394,453		35,658		230,334
105	(WRKSHT B, PART I)									
106	UNIT COST MULTIPLIER		5.062599		9.884096			356.580000		
107	(WRKSHT B, PT I)	.672323		10.221103		3.000647				.012115
108	COST TO BE ALLOCATED									
109	(WRKSHT B, PART II)									
110	UNIT COST MULTIPLIER									
111	(WRKSHT B, PT II)									
112	COST TO BE ALLOCATED	10,081	11,052	47,497	5,462	8,499		11,727		8,629
113	(WRKSHT B, PART III)									
114	UNIT COST MULTIPLIER		.371958		.793319			117.270000		
115	(WRKSHT B, PT III)	.097256		.820385		.064653				.000454

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET C  
 I I TO 12/31/2009 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	3,772,616		3,772,616		3,772,616
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 ANCILLARY SRVC COST CNTRS	3,067,839		3,067,839		3,067,839
44	LABORATORY	47,444		47,444		47,444
56	DRUGS CHARGED TO PATIENTS	275,999		275,999		275,999
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS	46,329		46,329		46,329
60	CLINIC					
61	EMERGENCY					
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	7,210,227		7,210,227		7,210,227
102	LESS OBSERVATION BEDS					
103	TOTAL	7,210,227		7,210,227		7,210,227

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET C  
 I I TO 12/31/2009 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	12,988,331		12,988,331			
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 ANCILLARY SRVC COST CNTRS	5,544,000		5,544,000			
44	LABORATORY	122,729		122,729	.386575	.386575	.386575
56	DRUGS CHARGED TO PATIENTS	286,280		286,280	.964088	.964088	.964088
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS	70,350		70,350	.658550	.658550	.658550
60	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	19,011,690		19,011,690			
102	LESS OBSERVATION BEDS						
103	TOTAL	19,011,690		19,011,690			

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
44	ANCILLARY SRVC COST CNTRS LABORATORY	47,444	1,388	46,056			47,444
56	DRUGS CHARGED TO PATIENTS	275,999	2,931	273,068			275,999
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS	46,329	499	45,830			46,329
60	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	369,772	4,818	364,954			369,772
102	LESS OBSERVATION BEDS						
103	TOTAL	369,772	4,818	364,954			369,772

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
44	LABORATORY	122,729	.386575	.386575
56	DRUGS CHARGED TO PATIENTS	286,280	.964088	.964088
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS	70,350	.658550	.658550
60	CLINIC			
61	EMERGENCY			
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	479,359		
102	LESS OBSERVATION BEDS			
103	TOTAL	479,359		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET D  
 I I TO 12/31/2009 I PART I  
 PPS

TITLE XVIII, PART A

WKST A LINE NO.	COST CENTER DESCRIPTION	CAPITAL REL COST (B, II) 1	OLD CAPITAL SWING BED ADJUSTMENT 2	REDUCED CAP RELATED COST 3	CAPITAL REL COST (B, III) 4	NEW CAPITAL SWING BED ADJUSTMENT 5	REDUCED CAP RELATED COST 6
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS				224,825		224,825
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
33	NURSERY						
101	TOTAL				224,825		224,825

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET D  
 I I TO 12/31/2009 I PART I  
 PPS

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	7,016	482			32.04	15,443
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
33	NURSERY						
101	TOTAL	7,016	482				15,443

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET D  
 I COMPONENT NO: I TO 12/31/2009 I PART II  
 I 15-4041 I I

TITLE XVIII, PART A HOSPITAL

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
44	ANCILLARY SRVC COST CNTRS LABORATORY		1,388	122,729	11,232		
56	DRUGS CHARGED TO PATIENTS		2,931	286,280	40,065		
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS		499	70,350			
60	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS						
101	TOTAL		4,818	479,359	51,297		

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET D  
 I COMPONENT NO: I TO 12/31/2009 I PART II  
 I 15-4041 I I

PPS

TITLE XVIII, PART A		HOSPITAL	
WKST A	COST CENTER DESCRIPTION	NEW CAPITAL	
LINE NO.		CST/CHRG RATIO	COSTS
		7	8
44	ANCILLARY SRVC COST CNTRS LABORATORY	.011309	127
56	DRUGS CHARGED TO PATIENTS	.010238	410
59	PSYCHIATRIC/PSYCHOLOGICAL	.007093	
60	OUTPAT SERVICE COST CNTRS CLINIC		
61	EMERGENCY		
62	OBSERVATION BEDS (NON-DIS		
	OTHER REIMBURS COST CNTRS		
101	TOTAL		537

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

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET D  
 I I TO 12/31/2009 I PART III  
 PPS

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					7,016	
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
33	NURSERY						
101	TOTAL					7,016	

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

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET D  
 I I TO 12/31/2009 I PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT PROG DAYS	INPAT PROGRAM PASS THRU COST
25	ADULTS & PEDIATRICS	7	8
26	INTENSIVE CARE UNIT		482
27	CORONARY CARE UNIT		
28	BURN INTENSIVE CARE UNIT		
29	SURGICAL INTENSIVE CARE U		
33	NURSERY		
101	TOTAL		482

TITLE XVIII, PART A HOSPITAL

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST	HOSPITAL	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
44	ANCILLARY SRVC COST CNTRS						
56	LABORATORY						
59	DRUGS CHARGED TO PATIENTS						
60	PSYCHIATRIC/PSYCHOLOGICAL						
61	OUTPAT SERVICE COST CNTRS						
62	CLINIC						
101	EMERGENCY						
	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
	TOTAL						

TITLE XVIII, PART A		HOSPITAL		PPS				
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			122,729			11,232	
56	DRUGS CHARGED TO PATIENTS			286,280			40,065	
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS			70,350				
60	CLINIC							
61	EMERGENCY							
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS							
101	TOTAL			479,359			51,297	

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A	COST CENTER DESCRIPTION	OUTPAT PROG CHARGES	OUTPAT PROG D,V COL 5.03	OUTPAT PROG D,V COL 5.04	OUTPAT PROG PASS THRU COST	COL 8.01 * COL 5	COL 8.02 * COL 5
LINE NO.		8	8.01	8.02	9	9.01	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						

## COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/10/2010
I	15-4041	I	FROM 1/ 1/2009	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 12/31/2009	I	PART I
I	15-4041	I		I	

TITLE XVIII PART A

HOSPITAL

PPS

## PART I - ALL PROVIDER COMPONENTS

1

## INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	7,016
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	7,016
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	7,016
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)	482
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	3,772,616
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	3,772,616

## PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	19,008,837
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	19,008,837
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.198466
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	2,709.36
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	3,772,616

TITLE XVIII PART A HOSPITAL PPS

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 537.72  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 259,181  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 259,181

	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					42,968
49 TOTAL PROGRAM INPATIENT COSTS					302,149

PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES 15,443  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES 537  
 52 TOTAL PROGRAM EXCLUDABLE COST 15,980  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN  
 ANESTHETIST, AND MEDICAL EDUCATION COSTS 286,169

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

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET D-1  
 I COMPONENT NO: I TO 12/31/2009 I PART III  
 I 15-4041 I I

TITLE XVIII PART A HOSPITAL PPS

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

1

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

PART IV - COMPUTATION OF OBSERVATION BED COST

- 83 TOTAL OBSERVATION BED DAYS
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 537.72
- 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		3,772,616			
87 NEW CAPITAL-RELATED COST	224,825	3,772,616	.059594		
88 NON PHYSICIAN ANESTHETIST		3,772,616			
89 MEDICAL EDUCATION		3,772,616			
89.01 MEDICAL EDUCATION - ALLIED HEA					
89.02 MEDICAL EDUCATION - ALL OTHER					

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET D-1  
 I COMPONENT NO: I TO 12/31/2009 I PART I  
 I 15-4041 I I

TITLE XIX - I/P

HOSPITAL

OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	7,016
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	7,016
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	7,016
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)	556
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	3,772,616
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	3,772,616

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	19,008,837
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	19,008,837
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.198466
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	2,709.36
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	3,772,616

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET D-1  
 I COMPONENT NO: I TO 12/31/2009 I PART II  
 I 15-4041 I I

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 537.72  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 298,972  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 298,972

	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				25,542
49	TOTAL PROGRAM INPATIENT COSTS				324,514

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

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET D-1  
 I COMPONENT NO: I TO 12/31/2009 I PART III  
 I 15-4041 I I

TITLE XIX - I/P HOSPITAL OTHER

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

1

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

PART IV - COMPUTATION OF OBSERVATION BED COST

- 83 TOTAL OBSERVATION BED DAYS
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 537.72
- 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

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET D-4  
 I COMPONENT NO: I TO 12/31/2009 I  
 I 15-4041 I

TITLE XVIII, PART A HOSPITAL

PPS

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		891,175	
26	INTENSIVE CARE UNIT			
27	CORONARY CARE UNIT			
28	BURN INTENSIVE CARE UNIT			
29	SURGICAL INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
44	LABORATORY	.386575	11,232	4,342
56	DRUGS CHARGED TO PATIENTS	.964088	40,065	38,626
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	.658550		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY			
62	OBSERVATION BEDS (NON-DISTINCT PART)			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		51,297	42,968
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		51,297	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET D-4  
 I COMPONENT NO: I TO 12/31/2009 I  
 I 15-4041 I

WKST A LINE NO.	TITLE XIX COST CENTER DESCRIPTION	HOSPITAL	RATIO COST	INPATIENT	INPATIENT
			TO CHARGES	CHARGES	COST
			1	2	3
25	INPAT ROUTINE SRVC CNTRS			1,028,100	
26	ADULTS & PEDIATRICS				
27	INTENSIVE CARE UNIT				
28	CORONARY CARE UNIT				
29	BURN INTENSIVE CARE UNIT				
29	SURGICAL INTENSIVE CARE UNIT				
44	ANCILLARY SRVC COST CNTRS				
44	LABORATORY		.386575	5,646	2,183
56	DRUGS CHARGED TO PATIENTS		.964088	20,043	19,323
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		.658550	6,128	4,036
60	OUTPAT SERVICE COST CNTRS				
61	CLINIC				
61	EMERGENCY				
62	OBSERVATION BEDS (NON-DISTINCT PART)				
62	OTHER REIMBURS COST CNTRS				
101	TOTAL			31,817	25,542
102	LESS PBP CLINIC LABORATORY SERVICES -				
102	PROGRAM ONLY CHARGES				
103	NET CHARGES			31,817	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO:	I PERIOD:	I PREPARED 5/10/2010
I 15-4041	I FROM 1/ 1/2009	I WORKSHEET E
I COMPONENT NO:	I TO 12/31/2009	I PART B
I 15-4041	I	I

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

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

COMPUTATION OF LESSER OF COST OR CHARGES

- REASONABLE CHARGES
- 6 ANCILLARY SERVICE CHARGES
- 7 INTERNS AND RESIDENTS SERVICE CHARGES
- 8 ORGAN ACQUISITION CHARGES
- 9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.
- 10 TOTAL REASONABLE CHARGES
- CUSTOMARY CHARGES
- 11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS
- 12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).
- 13 RATIO OF LINE 11 TO LINE 12
- 14 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)
- 15 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST
- 16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES
- 17 LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)
- 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

- 18 DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)
- 18.01 DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 17.01 (SEE INSTRUCTIONS)
- 19 SUBTOTAL (SEE INSTRUCTIONS)
- 20 SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)
- 21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS
- 22 ESRD DIRECT MEDICAL EDUCATION COSTS
- 23 SUBTOTAL
- 24 PRIMARY PAYER PAYMENTS
- 25 SUBTOTAL
- REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)
- 26 COMPOSITE RATE ESRD
- 27 BAD DEBTS (SEE INSTRUCTIONS)
- 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)
- 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES
- 28 SUBTOTAL
- 29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.
- 30 OTHER ADJUSTMENTS (SPECIFY)
- 30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)
- 31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.
- 32 SUBTOTAL
- 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)
- 34 INTERIM PAYMENTS
- 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)
- 35 BALANCE DUE PROVIDER/PROGRAM
- 36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2
- TO BE COMPLETED BY CONTRACTOR
- 50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)
- 51 OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)
- 52 THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY
- 53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)
- 54 TOTAL (SUM OF LINES 51 AND 53)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET E-1  
 I COMPONENT NO: I TO 12/31/2009 I  
 I 15-4041 I I

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		263,718		
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		NONE	NONE
4 TOTAL INTERIM PAYMENTS		263,718		
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER	.01			
TENTATIVE TO PROVIDER	.02			
TENTATIVE TO PROVIDER	.03			
TENTATIVE TO PROGRAM	.50			
TENTATIVE TO PROGRAM	.51			
TENTATIVE TO PROGRAM	.52			
SUBTOTAL	.99		NONE	NONE
6 DETERMINED NET SETTLEMENT		8,484		
AMOUNT (BALANCE DUE)	SETTLEMENT TO PROVIDER .01			
BASED ON COST REPORT (1)	SETTLEMENT TO PROGRAM .02			
7 TOTAL MEDICARE PROGRAM LIABILITY		272,202		

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

I	PROVIDER NO:	I	PERIOD:	I	PREPARED
I	15-4041	I	FROM 1/ 1/2009	I	5/10/2010
I	COMPONENT NO:	I	TO 12/31/2009	I	WORKSHEET E-3
I	15-4041	I		I	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)	
1.01	HOSPITAL SPECIFIC AMOUNT (SEE INSTRUCTIONS)	
1.02	ENTER FROM THE PS&R, THE IRF PPS PAYMENT	
1.03	MEDICARE 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)	311,302
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)	19.221918
1.17	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{((1 + (\text{LINE } 1.15/1.16))) \text{ RAISED TO THE POWER OF } .5150 - 1\}$ .	
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)	311,302
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)	311,302
	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 $\{((1 + (\text{LINE } 1.39/1.40))) \text{ RAISED TO THE POWER OF } .9012 - 1\}$ .	
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)	311,302
5	PRIMARY PAYER PAYMENTS	6,168
6	SUBTOTAL	305,134
7	DEDUCTIBLES	56,516
8	SUBTOTAL	248,618
9	COINSURANCE	
10	SUBTOTAL	248,618
11	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROF SERV)	33,692
11.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	23,584
11.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
12	SUBTOTAL	272,202
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

I PROVIDER NO:	I PERIOD:	I PREPARED 5/10/2010
I 15-4041	I FROM 1/ 1/2009	I WORKSHEET E-3
I COMPONENT NO:	I TO 12/31/2009	I PART I
I 15-4041	I	I

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

RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
17	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	272,202
18	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
19	INTERIM PAYMENTS	263,718
19.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
20	BALANCE DUE PROVIDER/PROGRAM	8,484
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, 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

I	PROVIDER NO:	I	PERIOD:	I	PREPARED
I	15-4041	I	FROM 1/ 1/2009	I	5/10/2010
I	COMPONENT NO:	I	TO 12/31/2009	I	WORKSHEET E-3
I	-	I		I	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			324,514	
2				
3				
4				
5				
6			324,514	
7				
8				
9			324,514	
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
10			1,028,100	
11			31,817	
12				
13				
14				
15				
16			1,059,917	
	CUSTOMARY CHARGES			
17				
18				
19				
20			1,059,917	
21			735,403	
22				
23			324,514	
	PROSPECTIVE PAYMENT AMOUNT			
24				
25				
26				
27				
28				
29				
30			324,514	
31				
32			324,514	
33				
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34				
35			324,514	
36				
37				
38				
38.01				
38.02				
38.03				
39				
40			324,514	
41				
42				
43				
44				
45				
46				
47				
48				
49				
50				
51				
52			324,514	
53				
54				
55			324,514	
56				
57			252,771	
57.01				
58			71,743	
59				

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/10/2010
I	15-4041	I	FROM 1/ 1/2009	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 12/31/2009	I	PART III
I	-	I		I	

IN LIEU OF FORM CMS-2552-96-E-3 (5/2008)

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

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

## BALANCE SHEET

I  
I  
IPROVIDER NO:  
15-4041I PERIOD:  
I FROM 1/ 1/2009  
I TO 12/31/2009I PREPARED 5/10/2010  
I  
I WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	599			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	748,289			
5	OTHER RECEIVABLES				
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7	INVENTORY				
8	PREPAID EXPENSES				
9	OTHER CURRENT ASSETS	34,050			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	782,938			
FIXED ASSETS					
12	LAND	479,312			
12.01	LAND IMPROVEMENTS				
13	LESS ACCUMULATED DEPRECIATION				
13.01	BUILDINGS	3,596,293			
14	LESS ACCUMULATED DEPRECIATION				
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT	552,114			
18.01	LESS ACCUMULATED DEPRECIATION	-875,638			
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	3,752,081			
OTHER ASSETS					
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS				
26	TOTAL OTHER ASSETS				
27	TOTAL ASSETS	4,535,019			

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I  
 I I TO 12/31/2009 I WORKSHEET G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	95,874			
29 SALARIES, WAGES & FEES PAYABLE	418,088			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)				
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	54,779			
36 TOTAL CURRENT LIABILITIES	568,741			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE				
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES	4,395,871			
42 TOTAL LONG-TERM LIABILITIES	4,395,871			
43 TOTAL LIABILITIES	4,964,612			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	-429,593			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	-429,593			
52 TOTAL LIABILITIES AND FUND BALANCES	4,535,019			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND	
	1	2
1 FUND BALANCE AT BEGINNING		-734,551
2 OF PERIOD		
3 NET INCOME (LOSS)		304,958
4 TOTAL		-429,593
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)		
6 ADDITIONS (CREDIT ADJUSTM		
7		
8		
9		
10 TOTAL ADDITIONS		
11 SUBTOTAL		-429,593
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)		
13 DEDUCTIONS (DEBIT ADJUSTM		
14		
15		
16		
17		
18 TOTAL DEDUCTIONS		
19 FUND BALANCE AT END OF		-429,593
PERIOD PER BALANCE SHEET		

SPECIFIC PURPOSE FUND

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET G-2  
 I I TO 12/31/2009 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	19,008,837		19,008,837
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
8 00 OTHER LONG TERM CARE			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	19,008,837		19,008,837
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT			
11 00 CORONARY CARE UNIT			
12 00 BURN INTENSIVE CARE UNIT			
13 00 SURGICAL INTENSIVE CARE UNIT			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	19,008,837		19,008,837
17 00 ANCILLARY SERVICES			
18 00 OUTPATIENT SERVICES			
24 00			
25 00 TOTAL PATIENT REVENUES	19,008,837		19,008,837

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		7,513,656	
ADD (SPECIFY)			
27 00 BAD DEBTS	170,575		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		170,575	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		7,684,231	

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET G-3  
 I I TO 12/31/2009 I

DESCRIPTION		
1	TOTAL PATIENT REVENUES	19,008,837
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	11,052,486
3	NET PATIENT REVENUES	7,956,351
4	LESS: TOTAL OPERATING EXPENSES	7,684,231
5	NET INCOME FROM SERVICE TO PATIENTS	272,120
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	
7	INCOME FROM INVESTMENTS	
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 OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	
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	OTHER INCOME	32,838
25	TOTAL OTHER INCOME	32,838
26	TOTAL	304,958
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	304,958

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET D-4  
 I COMPONENT NO: I TO 12/31/2009 I  
 I 15-4041 I I

WKST A LINE NO.	TITLE V COST CENTER DESCRIPTION	HOSPITAL	RATIO COST	INPATIENT	INPATIENT
			TO CHARGES	CHARGES	COST
			1	2	3
25	INPAT ROUTINE SRVC CNTRS			799,200	
26	ADULTS & PEDIATRICS				
27	INTENSIVE CARE UNIT				
28	CORONARY CARE UNIT				
29	BURN INTENSIVE CARE UNIT				
29	SURGICAL INTENSIVE CARE UNIT				
29	ANCILLARY SRVC COST CNTRS				
44	LABORATORY		.386575	3,336	1,290
56	DRUGS CHARGED TO PATIENTS		.964088	16,239	15,656
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		.658550	4,500	2,963
60	OUTPAT SERVICE COST CNTRS				
61	CLINIC				
61	EMERGENCY				
62	OBSERVATION BEDS (NON-DISTINCT PART)				
62	OTHER REIMBURS COST CNTRS				
101	TOTAL			24,075	19,909
102	LESS PBP CLINIC LABORATORY SERVICES -				
102	PROGRAM ONLY CHARGES				
103	NET CHARGES			24,075	

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET D-1  
 I COMPONENT NO: I TO 12/31/2009 I PART I  
 I 15-4041 I I

TITLE V - I/P

HOSPITAL

OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	7,016
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	7,016
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	7,016
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)	432
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	3,772,616
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)	3,772,616
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	19,008,837
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	19,008,837
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.198466
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	2,709.36
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	3,772,616

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET D-1  
 I COMPONENT NO: I TO 12/31/2009 I PART II  
 I 15-4041 I I

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 537.72  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 232,295  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 232,295

	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST
	1	2	3	4	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  
 48 PROGRAM INPATIENT ANCILLARY SERVICE COST 19,909  
 49 TOTAL PROGRAM INPATIENT COSTS 252,204

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

I PROVIDER NO: I PERIOD: I PREPARED 5/10/2010  
 I 15-4041 I FROM 1/ 1/2009 I WORKSHEET D-1  
 I COMPONENT NO: I TO 12/31/2009 I PART III  
 I 15-4041 I I

TITLE V - I/P HOSPITAL OTHER

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

1

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

PART IV - COMPUTATION OF OBSERVATION BED COST

- 83 TOTAL OBSERVATION BED DAYS
- 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					