

Ranken Jordan
Title XVIII Medicare Cost Report
Provider No. 26-3303
June 30, 2009



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

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET 5
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	26-3303	I	FROM 7/ 1/2008	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 6/30/2009	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
						--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 10/29/2009 TIME 8:36

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY: RANKEN JORDAN 26-3303 FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2008 AND ENDING 6/30/2009 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		TITLE XVIII		TITLE XIX	
		1	A 2	B 3	4		
1	HOSPITAL						
100	TOTAL	0	0	0	0	1,889,488	1,889,488
		0			0	1,889,488	

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

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET S-2
 I I TO 6/30/2009 I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

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

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

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

OTHER INFORMATION

- 21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.
- 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? N
- 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
- 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 1 N Y 7040
- 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. Y
- 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
- 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). / /
- 25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R?
- 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)

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET S-2
 I I TO 6/30/2009 I

25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(c)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)

26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.

26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: 0 / /

26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.

28 IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02

28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)

	1	2	3	4
28.02	0	0.0000	0.0000	
	0.00	0		

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

A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)

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

29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? N

30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) N

30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70

30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)

30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).

30.04 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II 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)?

35.04 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)

36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE

V XVIII XIX
 1 2 3
 N N N

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET S-2
 I I TO 6/30/2009 I

37 WITH 42 CFR 412.320? (SEE INSTRUCTIONS) N N N
 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? N
 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? Y
 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 NUMBER. (SEE INSTRUCTIONS). N

40.01 NAME: FI/CONTRACTOR NAME
 40.02 STREET: P.O. BOX: FI/CONTRACTOR #
 40.03 CITY: STATE: ZIP CODE: -

41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2. N 00/00/0000
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?
 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?
 46 IF YOU ARE PARTICIPATING IN THE NHCMP 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	OUTPATIENT	OUTPATIENT
	1	2	3	4	ASC	RADIOLOGY	DIAGNOSTIC
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: 171,274
 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.

	DATE	Y OR N	LIMIT	Y OR N	FEES
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.		N	0.00		0
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N

58 ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. N

58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(ii)(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). N 0

59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX
IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
I 26-3303 I FROM 7/ 1/2008 I WORKSHEET S-2
I I TO 6/30/2009 I

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					
62.01					0.00
62.02					0.00
62.03					0.00
62.04					0.00
62.05					0.00
62.06					0.00
62.07					0.00
62.08					0.00
62.09					0.00

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

IN LIEU OF FORM CMS-2552-96 (04/2005)
 I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET S-3
 I I TO 6/30/2009 I PART I

COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH N/A	I/P DAYS / TITLE	O/P VISITS / NOT LTCH	TRIPS / TOTAL
1 ADULTS & PEDIATRICS	34	12,410	2.01	3	4.01	5
2 HMO						5,151
2 01 HMO - (IRF PPS SUBPROVIDER)						4,283
3 ADULTS & PED-SB SNF						
4 ADULTS & PED-SB NF						
5 TOTAL ADULTS AND PEDS	34	12,410				
12 TOTAL	34	12,410				5,151
13 RPCH VISITS						5,151
25 TOTAL	34					
26 OBSERVATION BED DAYS						
27 AMBULANCE TRIPS						
28 EMPLOYEE DISCOUNT DAYS						
28 01 EMP DISCOUNT DAYS -IRF						

COMPONENT	TITLE XIX ADMITTED	I/P DAYS / OBSERVATION BEDS NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	TRIPS / TOTAL OBSERVATION BEDS ADMITTED	DISCHARGES / TOTAL OBSERVATION BEDS NOT ADMITTED	INTERNS & RES. / TOTAL	FTES / LESS I&R REPL NON-PHYS ANES
1 ADULTS & PEDIATRICS	5.01	5.02	6	6.01	6.02	7	8
2 HMO			10,863				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS			10,863				
12 TOTAL			10,863				
13 RPCH VISITS							
25 TOTAL							
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I & R FTES NET	FULL TIME EMPLOYEES ON PAYROLL	EQUIV NONPAID WORKERS	DISCHARGES / TITLE	DISCHARGES / TITLE	TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	9	10	11	12	13	15
2 HMO						81
2 01 HMO - (IRF PPS SUBPROVIDER)						205
3 ADULTS & PED-SB SNF						
4 ADULTS & PED-SB NF						
5 TOTAL ADULTS AND PEDS						
12 TOTAL		193.48				81
13 RPCH VISITS						205
25 TOTAL		193.48				
26 OBSERVATION BED DAYS						
27 AMBULANCE TRIPS						
28 EMPLOYEE DISCOUNT DAYS						
28 01 EMP DISCOUNT DAYS -IRF						

HOSPITAL UNCOMPENSATED CARE DATA

IN LIEU OF FORM CMS-2552-96 S-10 (05/2004)
 I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET S-10
 I I TO 6/30/2009 I
 I I I

DESCRIPTION

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

- UNCOMPENSATED CARE REVENUES
- 17 REVENUE FROM UNCOMPENSATED CARE
- 17.01 GROSS MEDICAID REVENUES
- 18 REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS
- 19 REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)
- 20 RESTRICTED GRANTS
- 21 NON-RESTRICTED GRANTS
- 22 TOTAL GROSS UNCOMPENSATED CARE REVENUES

- UNCOMPENSATED CARE COST
- 23 TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS
- 24 COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103) .637786
- 25 TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)
- 26 TOTAL SCHIP CHARGES FROM YOUR RECORDS
- 27 TOTAL SCHIP COST, (LINE 24 * LINE 26)
- 28 TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS 25,859,291

HOSPITAL UNCOMPENSATED CARE DATA

IN LIEU OF FORM CMS-2552-96 S-10 (05/2004)
I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
I 26-3303 I FROM 7/ 1/2008 I WORKSHEET S-10
I I TO 6/30/2009 I
I I I

DESCRIPTION

29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	16,492,694
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29)	16,492,694

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSESI PROVIDER NO:
I 26-3303
II PERIOD:
I FROM 7/ 1/2008
I TO 6/30/2009
II PREPARED 10/29/2009
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					
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		1,062,181	1,062,181	517,975	1,580,156
5	0500 EMPLOYEE BENEFITS				320,867	320,867
6	0600 ADMINISTRATIVE & GENERAL	168,039	2,140,981	2,309,020		2,309,020
7	0700 MAINTENANCE & REPAIRS	1,922,255	2,591,044	4,513,299	280,312	4,793,611
11	1100 DIETARY	342,391	528,228	870,619		870,619
14	1400 NURSING ADMINISTRATION	196,612	65,775	262,387		262,387
18	1800 SOCIAL SERVICE	183,286	3,035	186,321	534,635	720,956
	INPAT ROUTINE SRVC CNTRS		81,526	203,382		203,382
25	2500 ADULTS & PEDIATRICS	5,031,823	1,096,266	6,128,089	-897,653	5,230,436
	ANCILLARY SRVC COST CNTRS					
41	4100 RADIOLOGY-DIAGNOSTIC		79,550	79,550		79,550
44	4400 LABORATORY		54,999	54,999		54,999
49	4900 RESPIRATORY THERAPY	781,885	606,445	1,388,330		1,388,330
50	5000 PHYSICAL THERAPY	1,449,797	94,957	1,544,754	-93,988	1,450,766
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	172,841	1,853	174,694	363,018	537,712
56	5600 DRUGS CHARGED TO PATIENTS	233,631	570,093	803,724		803,724
	OUTPAT SERVICE COST CNTRS					
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
68	5950 OTHER REIMBURSABLE COST CENTERS		84,607	84,607		84,607
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		1,025,166	1,025,166	-1,025,166	
90	9000 OTHER CAPITAL RELATED COSTS					
95	SUBTOTALS	10,604,416	10,086,706	20,691,122	-0-	20,691,122
	NONREIMBURS COST CENTERS					
100	7950 RESPITE					
101	TOTAL	10,604,416	10,086,706	20,691,122	-0-	20,691,122

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:	I PERIOD:	I PREPARED 10/29/2009
I 26-3303	I FROM 7/ 1/2008	I WORKSHEET A
I	I TO 6/30/2009	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		1,918,856
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	338,700	320,867
5	0500 EMPLOYEE BENEFITS		2,106,434
6	0600 ADMINISTRATIVE & GENERAL	-202,586	4,288,327
7	0700 MAINTENANCE & REPAIRS	-505,284	870,619
11	1100 DIETARY		262,387
14	1400 NURSING ADMINISTRATION		720,956
18	1800 SOCIAL SERVICE		203,382
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-1,144,500	4,085,936
	ANCILLARY SRVC COST CNTRS		
41	4100 RADIOLOGY-DIAGNOSTIC		79,550
44	4400 LABORATORY		54,999
49	4900 RESPIRATORY THERAPY		1,388,330
50	5000 PHYSICAL THERAPY		1,450,766
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		537,712
56	5600 DRUGS CHARGED TO PATIENTS		803,724
	OUTPAT SERVICE COST CNTRS		
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
	OTHER REIMBURS COST CNTRS		
68	5950 OTHER REIMBURSABLE COST CENTERS		84,607
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
90	9000 OTHER CAPITAL RELATED COSTS		-0-
95	SUBTOTALS	-1,513,670	19,177,452
	NONREIMBURS COST CENTERS		
100	7950 RESPITE		
101	TOTAL	-1,513,670	19,177,452

COST CENTERS USED IN COST REPORT

IN LIEU OF FORM CMS-2552-96(7/2009)
 I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I NOT A CMS WORKSHEET
 I I TO 6/30/2009 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	
11	DIETARY	1100	
14	NURSING ADMINISTRATION	1400	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
	ANCILLARY SRVC COST		
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	OTHER REIMBURS COST		
68	OTHER REIMBURSABLE COST CENTERS	5950	OTHER REIMBURSABLE COST CENTERS
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS		
	NONREIMBURS COST CEN		OLD CAP REL COSTS-BLDG & FIXT
100	RESPITE	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO: 263303	PERIOD: FROM 7/ 1/2008 TO 6/30/2009	PREPARED 10/29/2009 WORKSHEET A-6
------------------------	---	--------------------------------------

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1)	COST CENTER	LINE NO	SALARY	OTHER
	1	2	3	4	5
1 TO RECLASS DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-MVBLE EQUIP	4		312,589
2 TO RECLASS INTEREST EXPENSE	B	NEW CAP REL COSTS-BLDG & FIXT	3		1,025,166
3 TO RECLASS INSURANCE EXPENSE	C	ADMINISTRATIVE & GENERAL	6		186,324
4		OTHER CAPITAL RELATED COSTS	90		61,304
5 TO RECLASS FRONT DESK SALARY	D	ADMINISTRATIVE & GENERAL	6	93,988	
6 TO RECLASS NURSING ADMIN AND SUPERVI	E	NURSING ADMINISTRATION	14	534,635	
7 TO RECLASS MEDICAL SUPPLY EXPENSE	F	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		363,018
36 TOTAL RECLASSIFICATIONS				628,623	1,948,401

(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
263303	FROM 7/ 1/2008	10/29/2009
	TO 6/30/2009	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1) COST CENTER	DECREASE		SALARY	OTHER	A-7 REF 10
		LINE NO				
	1	6	7	8	9	
1 TO RECLASS DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		312,589	9
2 TO RECLASS INTEREST EXPENSE	B	INTEREST EXPENSE	88		1,025,166	11
3 TO RECLASS INSURANCE EXPENSE	C	NEW CAP REL COSTS-BLDG & FIXT	3		247,628	12
4						12
5 TO RECLASS FRONT DESK SALARY	D	PHYSICAL THERAPY	50	93,988		
6 TO RECLASS NURSING ADMIN AND SUPERVI	E	ADULTS & PEDIATRICS	25	534,635		
7 TO RECLASS MEDICAL SUPPLY EXPENSE	F	ADULTS & PEDIATRICS	25		363,018	
36 TOTAL RECLASSIFICATIONS				628,623	1,948,401	

(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

IN LIEU OF FORM CMS-2552-96 (09/1996)
 PROVIDER NO: 263303 PERIOD: FROM 7/ 1/2008 TO 6/30/2009
 PREPARED 10/29/2009 WORKSHEET A-6 NOT A CMS WORKSHEET

RECLASS CODE: A
 EXPLANATION : TO RECLASS DEPRECIATION EXPENSE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	312,589
TOTAL RECLASSIFICATIONS FOR CODE A			312,589

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
NEW CAP REL COSTS-BLDG & FIXT	3	312,589	
		312,589	

RECLASS CODE: B
 EXPLANATION : TO RECLASS INTEREST EXPENSE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	1,025,166
TOTAL RECLASSIFICATIONS FOR CODE B			1,025,166

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
INTEREST EXPENSE	88	1,025,166	
		1,025,166	

RECLASS CODE: C
 EXPLANATION : TO RECLASS INSURANCE EXPENSE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	186,324
2.00	OTHER CAPITAL RELATED COSTS	90	61,304
TOTAL RECLASSIFICATIONS FOR CODE C			247,628

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
NEW CAP REL COSTS-BLDG & FIXT	3	247,628	
		0	
		247,628	

RECLASS CODE: D
 EXPLANATION : TO RECLASS FRONT DESK SALARY

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	93,988
TOTAL RECLASSIFICATIONS FOR CODE D			93,988

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
PHYSICAL THERAPY	50	93,988	
		93,988	

RECLASS CODE: E
 EXPLANATION : TO RECLASS NURSING ADMIN AND SUPERVI

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NURSING ADMINISTRATION	14	534,635
TOTAL RECLASSIFICATIONS FOR CODE E			534,635

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADULTS & PEDIATRICS	25	534,635	
		534,635	

RECLASS CODE: F
 EXPLANATION : TO RECLASS MEDICAL SUPPLY EXPENSE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	363,018
TOTAL RECLASSIFICATIONS FOR CODE F			363,018

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADULTS & PEDIATRICS	25	363,018	
		363,018	

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
				DONATION 3					
1	LAND	2,359,177						2,359,177	
2	LAND IMPROVEMENTS								
3	BUILDINGS & FIXTURE	19,499,093	374,333			374,333		19,873,426	
4	BUILDING IMPROVEMEN								
5	FIXED EQUIPMENT								
6	MOVABLE EQUIPMENT	2,433,832	1,057,872			1,057,872	21,029	3,470,675	
7	SUBTOTAL	24,292,102	1,432,205			1,432,205	21,029	25,703,278	
8	RECONCILING ITEMS								
9	TOTAL	24,292,102	1,432,205			1,432,205	21,029	25,703,278	

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	22,232,603		22,232,603	.864972	53,026			53,026
4	NEW CAP REL COSTS-MV	3,470,675		3,470,675	.135028	8,278			8,278
5	TOTAL	25,703,278		25,703,278	1.000000	61,304			61,304

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL							TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14		
3	NEW CAP REL COSTS-BL	490,467		1,021,816	53,026	7,610	345,937	1,918,856	
4	NEW CAP REL COSTS-MV	312,589		8,278				320,867	
5	TOTAL	803,056		1,021,816	61,304	7,610	345,937	2,239,723	

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL							TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14		
3	NEW CAP REL COSTS-BL	803,056			247,628	7,610	3,887	1,062,181	
4	NEW CAP REL COSTS-MV								
5	TOTAL	803,056			247,628	7,610	3,887	1,062,181	

* 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

IN LIEU OF FORM CMS-2552-96(05/1999)
 I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET A-8
 I I TO 6/30/2009 I

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST. A-7 REF. 5
			COST CENTER	LINE NO	
1 INVST INCOME-OLD BLDGS AND FIXTURES					
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	1	
3 INVST INCOME-NEW BLDGS AND FIXTURES			**COST CENTER DELETED**	2	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP	B	-3,350	NEW CAP REL COSTS-BLDG &	3	11
5 INVESTMENT INCOME-OTHER			NEW CAP REL COSTS-MVBLE E	4	
6 TRADE, QUANTITY AND TIME DISCOUNTS					
7 REFUNDS AND REBATES OF EXPENSES					
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9 TELEPHONE SERVICES					
10 TELEVISION AND RADIO SERVICE					
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-1,134,500			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS					
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS					
18 SALE OF MED AND SURG SUPPLIES					
19 SALE OF DRUGS TO OTHER THAN PATIENTS					
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-10,098	ADMINISTRATIVE & GENERAL	6	
21 NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22 VENDING MACHINES					
23 INCOME FROM IMPOSITION OF INTEREST					
24 INTRST EXP ON MEDICARE OVERPAYMENTS					
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28 UTILIZATION REVIEW-PHYSIAN COMP					
29 DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	89	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	1	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			**COST CENTER DELETED**	2	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-BLDG &	3	
33 NON-PHYSICIAN ANESTHETIST			NEW CAP REL COSTS-MVBLE E	4	
34 PHYSICIANS' ASSISTANT			**COST CENTER DELETED**	20	
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37 LOBBYING EXPENSE	A	-9,969	ADMINISTRATIVE & GENERAL	6	
38 MARKETING EXPENSE	A	-228,399	ADMINISTRATIVE & GENERAL	6	
39 DEVELOPMENT SALARY EXPENSE	A	-153,599	ADMINISTRATIVE & GENERAL	6	
40 DEVELOPMENT BENEFITS EXPENSE	A	-38,600	EMPLOYEE BENEFITS	5	
41 DEVELOPMENT OTHER EXPENSE	A	-92,609	ADMINISTRATIVE & GENERAL	6	
42 MISCELLANEOUS REVENUE	B	-1,707	EMPLOYEE BENEFITS	5	
43 MISCELLANEOUS REVENUE	B	-16,178	ADMINISTRATIVE & GENERAL	6	
44 LOSS ON EARLY EXTINGUISHMENT OF DEBT	A	342,050	NEW CAP REL COSTS-BLDG &	3	14
45 COUNTRY CLUB DUES	A	-10,023	ADMINISTRATIVE & GENERAL	6	
46 HEALTHLINK ADMINISTRATIVE EXPENSES	A	15,591	ADMINISTRATIVE & GENERAL	6	
47 PHYSICIAN RECRUITMENT EXPENSE	A	-10,000	ADULTS & PEDIATRICS	25	
48 PROVIDER BASED PHYSICIAN BENEFIT EXP	A	-162,279	EMPLOYEE BENEFITS	5	
49					
50 TOTAL (SUM OF LINES 1 THRU 49)		-1,513,670			

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

IN LIEU OF FORM CMS-2552-96(9/1996)
 I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET A-8-2
 I I TO 6/30/2009 I GROUP 1

LINE NO.	WKSHT A 1	COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN- ERATION 3	PROFES- SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	25	ADULTS AND PEDS/ AGGREGAT	1,171,807	1,128,382	43,425	140,600	520	35,150	1,758
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	1,171,807	1,128,382	43,425		520	35,150	1,758

PROVIDER BASED PHYSICIAN ADJUSTMENTS

IN LIEU OF FORM CMS-2552-96(9/1996)
 I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET A-8-2
 I I TO 6/30/2009 I GROUP 1

LINE NO.	WKSHT A 10	COST CENTER/ PHYSICIAN IDENTIFIER 11	COST OF MEMBERSHIPS & CONTINUING EDUCATION 12	PROVIDER COMPONENT SHARE OF COL 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COL 14 15	ADJUSTED RCE LIMIT 16	RCE DIS- ALLOWANCE 17	ADJUSTMENT 18
1	25	ADULTS AND PEDS/ AGGREGAT			58,209	2,157	37,307	6,118	1,134,500
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			58,209	2,157	37,307	6,118	1,134,500

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I NOT A CMS WORKSHEET
 I I TO 6/30/2009 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	3	SQUARE	FEET	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	ENTERED
18	SOCIAL SERVICE	17	TIME	SPENT	ENTERED

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET B
 I I TO 6/30/2009 I PART I

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL COSTS-BLDG & OSTS	NEW CAP REL COSTS-MVBLE E OSTS	EMPLOYEE BENEFITS	SUBTOTAL	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
	0	3	4	5	5a.00	6	7
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	1,918,856	1,918,856					
005 NEW CAP REL COSTS-MVBLE E	320,867		320,867				
006 EMPLOYEE BENEFITS	2,106,434			2,106,434			
007 ADMINISTRATIVE & GENERAL	4,288,327	314,207	52,541	425,296	5,080,371	5,080,371	
011 MAINTENANCE & REPAIRS	870,619	315,035	52,679	78,178	1,316,511	474,451	1,790,962
014 DIETARY	262,387	51,599	8,628	44,892	367,506	132,444	71,658
018 NURSING ADMINISTRATION	720,956	125,447	20,977	163,922	1,031,302	371,666	174,216
025 SOCIAL SERVICE	203,382	49,116	8,213	27,823	288,534	103,983	68,210
041 INPAT ROUTINE SRVC CNTRS							
044 ADULTS & PEDIATRICS	4,085,936	904,709	151,284	785,415	5,927,344	2,136,119	1,256,423
049 ANCILLARY SRVC COST CNTRS							
050 RADIOLOGY-DIAGNOSTIC	79,550				79,550	28,669	
055 LABORATORY	54,999				54,999	19,821	
056 RESPIRATORY THERAPY	1,388,330			178,527	1,566,857	564,672	
062 PHYSICAL THERAPY	1,450,766	158,743	26,545	309,571	1,945,625	701,174	220,455
068 MEDICAL SUPPLIES CHARGED	537,712			39,465	577,177	208,006	
095 DRUGS CHARGED TO PATIENTS	803,724			53,345	857,069	308,875	
100 OUTPAT SERVICE COST CNTRS							
101 OBSERVATION BEDS (NON-DIS							
102 OTHER REIMBURS COST CNTRS	84,607				84,607	30,491	
103 OTHER REIMBURSABLE COST C							
104 SPEC PURPOSE COST CENTERS							
105 SUBTOTALS	19,177,452	1,918,856	320,867	2,106,434	19,177,452	5,080,371	1,790,962
106 NONREIMBURS COST CENTERS							
107 RESPITE							
108 CROSS FOOT ADJUSTMENT							
109 NEGATIVE COST CENTER							
110 TOTAL	19,177,452	1,918,856	320,867	2,106,434	19,177,452	5,080,371	1,790,962

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	DIETARY	NURSING ADMINISTRATION	SOCIAL SERVICE	SUBTOTAL	I&R COST POST STEP-DOWN ADJ 26	TOTAL
003 GENERAL SERVICE COST CNTR	11	14	18	25	26	27
004 NEW CAP REL COSTS-BLDG &						
005 NEW CAP REL COSTS-MVBLE E						
006 EMPLOYEE BENEFITS						
007 ADMINISTRATIVE & GENERAL						
011 MAINTENANCE & REPAIRS						
014 DIETARY	571,608					
018 NURSING ADMINISTRATION		1,577,184				
025 SOCIAL SERVICE			460,727			
041 INPAT ROUTINE SRVC CNTRS						
044 ADULTS & PEDIATRICS	571,608	1,577,184	460,727	11,929,405		11,929,405
049 ANCILLARY SRVC COST CNTRS						
050 RADIOLOGY-DIAGNOSTIC					108,219	108,219
055 LABORATORY					74,820	74,820
056 RESPIRATORY THERAPY					2,131,529	2,131,529
062 PHYSICAL THERAPY					2,867,254	2,867,254
068 MEDICAL SUPPLIES CHARGED					785,183	785,183
095 DRUGS CHARGED TO PATIENTS					1,165,944	1,165,944
100 OUTPAT SERVICE COST CNTRS						
101 OBSERVATION BEDS (NON-DIS						
102 OTHER REIMBURS COST CNTRS						
103 OTHER REIMBURSABLE COST C					115,098	115,098
100 SPEC PURPOSE COST CENTERS						
101 SUBTOTALS	571,608	1,577,184	460,727	19,177,452		19,177,452
102 NONREIMBURS COST CENTERS						
103 RESPIRE						
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 TOTAL	571,608	1,577,184	460,727	19,177,452		19,177,452

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET B
 I I TO 6/30/2009 I PART III

ALLOCATION OF NEW CAPITAL RELATED COSTS

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							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL	34,288	314,207	52,541	401,036		401,036	
011 MAINTENANCE & REPAIRS	5,831	315,035	52,679	373,545		37,452	410,997
014 DIETARY		51,599	8,628	60,227		10,455	16,444
018 NURSING ADMINISTRATION		125,447	20,977	146,424		29,338	39,980
025 SOCIAL SERVICE		49,116	8,213	57,329		8,208	15,653
041 INPAT ROUTINE SRVC CNTRS		904,709	151,284	1,055,993		168,623	288,329
044 ADULTS & PEDIATRICS							
049 ANCILLARY SRVC COST CNTRS						2,263	
050 RADIOLOGY-DIAGNOSTIC						1,565	
055 LABORATORY						44,574	
056 RESPIRATORY THERAPY	125,680			125,680		55,349	50,591
062 PHYSICAL THERAPY		158,743	26,545	185,288		16,420	
068 MEDICAL SUPPLIES CHARGED	124,678			124,678		24,382	
095 DRUGS CHARGED TO PATIENTS							
100 OUTPAT SERVICE COST CNTRS							
101 OBSERVATION BEDS (NON-DIS							
102 OTHER REIMBURS COST CNTRS							
103 OTHER REIMBURSABLE COST C						2,407	
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	290,477	1,918,856	320,867	2,530,200		401,036	410,997
100 NONREIMBURS COST CENTERS							
101 RESPIRE							
102 CROSS FOOT ADJUSTMENTS							
103 NEGATIVE COST CENTER							
TOTAL	290,477	1,918,856	320,867	2,530,200		401,036	410,997

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET B
 I I TO 6/30/2009 I PART III

	DIETARY	NURSING ADMIN ISTRATION	SOCIAL SERVIC E	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	11	14	18	25	26	27
003 GENERAL SERVICE COST CNTR						
004 NEW CAP REL COSTS-BLDG &						
005 NEW CAP REL COSTS-MVBLE E						
006 EMPLOYEE BENEFITS						
007 ADMINISTRATIVE & GENERAL						
011 MAINTENANCE & REPAIRS						
014 DIETARY	87,126					
018 NURSING ADMINISTRATION		215,742				
025 SOCIAL SERVICE			81,190			
041 INPAT ROUTINE SRVC CNTRS						
044 ADULTS & PEDIATRICS	87,126	215,742	81,190	1,897,003		1,897,003
049 ANCILLARY SRVC COST CNTRS						
050 RADIOLOGY-DIAGNOSTIC				2,263		2,263
055 LABORATORY				1,565		1,565
056 RESPIRATORY THERAPY				170,254		170,254
062 PHYSICAL THERAPY				291,228		291,228
068 MEDICAL SUPPLIES CHARGED				141,098		141,098
095 DRUGS CHARGED TO PATIENTS				24,382		24,382
100 OUTPAT SERVICE COST CNTRS						
101 OBSERVATION BEDS (NON-DIS						
102 OTHER REIMBURS COST CNTRS						
103 OTHER REIMBURSABLE COST C				2,407		2,407
095 SPEC PURPOSE COST CENTERS						
100 SUBTOTALS	87,126	215,742	81,190	2,530,200		2,530,200
101 NONREIMBURS COST CENTERS						
102 RESPITE						
103 CROSS FOOT ADJUSTMENTS						
102 NEGATIVE COST CENTER						
103 TOTAL	87,126	215,742	81,190	2,530,200		2,530,200

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET B-1
 I I TO 6/30/2009 I

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	S RECONCIL-) IATION	ADMINISTRATIV	MAINTENANCE &
	OSTS-BLDG &	OSTS-MVBLE E	FITS		E & GENERAL	REPAIRS
	(SQUARE FEET	(SQUARE) FEET	(GROSS)ALARIES		(ACCUM. COST	(SQUARE) FEET
	3	4	5	6a.00	6	7
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	60,282					
005 NEW CAP REL COSTS-MVB		60,282				
006 EMPLOYEE BENEFITS			9,225,437			
007 ADMINISTRATIVE & GENE	9,871	9,871	1,862,644	-5,080,371	14,097,081	
011 MAINTENANCE & REPAIRS	9,897	9,897	342,391		1,316,511	40,514
014 DIETARY	1,621	1,621	196,612		367,506	1,621
018 NURSING ADMINISTRATIO	3,941	3,941	717,921		1,031,302	3,941
025 SOCIAL SERVICE	1,543	1,543	121,856		288,534	1,543
041 INPAT ROUTINE SRVC CN						
044 ADULTS & PEDIATRICS	28,422	28,422	3,439,847		5,927,344	28,422
049 ANCILLARY SRVC COST C						
050 RADIOLOGY-DIAGNOSTIC					79,550	
055 LABORATORY					54,999	
056 RESPIRATORY THERAPY			781,885		1,566,857	
062 PHYSICAL THERAPY	4,987	4,987	1,355,809		1,945,625	4,987
068 MEDICAL SUPPLIES CHAR			172,841		577,177	
095 DRUGS CHARGED TO PATI			233,631		857,069	
100 OUTPAT SERVICE COST C						
101 OBSERVATION BEDS (NON						
102 OTHER REIMBURS COST C						
103 OTHER REIMBURSABLE CO					84,607	
104 SPEC PURPOSE COST CEN						
105 SUBTOTALS	60,282	60,282	9,225,437	-5,080,371	14,097,081	40,514
106 NONREIMBURS COST CENT						
107 RESPITE						
108 CROSS FOOT ADJUSTMENT						
109 NEGATIVE COST CENTER						
110 COST TO BE ALLOCATED	1,918,856	320,867	2,106,434		5,080,371	1,790,962
111 (WRKSHT B, PART I)						
112 UNIT COST MULTIPLIER	31.831326		.228329		.360385	
113 (WRKSHT B, PT I)		5.322766				44.206003
114 COST TO BE ALLOCATED						
115 (WRKSHT B, PART II)						
116 UNIT COST MULTIPLIER						
117 (WRKSHT B, PT II)						
118 COST TO BE ALLOCATED					401,036	410,997
119 (WRKSHT B, PART III)						
120 UNIT COST MULTIPLIER					.028448	
121 (WRKSHT B, PT III)						10.144567

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET B-1
 I I TO 6/30/2009 I

COST CENTER DESCRIPTION	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION S(DIRECT)SING HRS	SOCIAL SERVICE NR(TIME)SPENT
GENERAL SERVICE COST	11	14	18
003 NEW CAP REL COSTS-BLD			
004 NEW CAP REL COSTS-MVB			
005 EMPLOYEE BENEFITS			
006 ADMINISTRATIVE & GENE			
007 MAINTENANCE & REPAIRS			
011 DIETARY	10,863		
014 NURSING ADMINISTRATION		153,553	
018 SOCIAL SERVICE			6,330
025 INPAT ROUTINE SRVC CN ADULTS & PEDIATRICS	10,863	153,553	6,330
041 ANCILLARY SRVC COST C			
044 RADIOLOGY-DIAGNOSTIC LABORATORY			
049 RESPIRATORY THERAPY			
050 PHYSICAL THERAPY			
055 MEDICAL SUPPLIES CHAR			
056 DRUGS CHARGED TO PATI			
062 OUTPAT SERVICE COST C			
068 OBSERVATION BEDS (NON OTHER REIMBURS COST C			
095 OTHER REIMBURSABLE CO SPEC PURPOSE COST CEN			
NONREIMBURS COST CENT	10,863	153,553	6,330
100 RESPIRE			
101 CROSS FOOT ADJUSTMENT			
102 NEGATIVE COST CENTER			
103 COST TO BE ALLOCATED (PER WRKSHT B, PART	571,608	1,577,184	460,727
104 UNIT COST MULTIPLIER (WRKSHT B, PT I)	52.619718	10.271268	72.784676
105 COST TO BE ALLOCATED (PER WRKSHT B, PART			
106 UNIT COST MULTIPLIER (WRKSHT B, PT II)	87,126	215,742	81,190
107 COST TO BE ALLOCATED (PER WRKSHT B, PART			
108 UNIT COST MULTIPLIER (WRKSHT B, PT III)	8.020436	1.405000	12.826224

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET C
 I I TO 6/30/2009 I PART I

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	11,929,405		11,929,405		
41	ANCILLARY SRVC COST CNTRS					
44	RADIOLOGY-DIAGNOSTIC	108,219		108,219		
49	LABORATORY	74,820		74,820		
50	RESPIRATORY THERAPY	2,131,529		2,131,529		
55	PHYSICAL THERAPY	2,867,254		2,867,254		
56	MEDICAL SUPPLIES CHARGED	785,183		785,183		
56	DRUGS CHARGED TO PATIENTS	1,165,944		1,165,944		
62	OUTPAT SERVICE COST CNTRS					
68	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS					
101	OTHER REIMBURSABLE COST C	115,098		115,098		
102	SUBTOTAL	19,177,452		19,177,452		
103	LESS OBSERVATION BEDS					
	TOTAL	19,177,452		19,177,452		

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	19,680,818		19,680,818			
41	ANCILLARY SRVC COST CNTRS						
44	RADIOLOGY-DIAGNOSTIC	68,962		68,962	1.569256	1.569256	
49	LABORATORY	206,241		206,241	.362779	.362779	
50	RESPIRATORY THERAPY	5,884,576		5,884,576	.362223	.362223	
55	PHYSICAL THERAPY	1,505,987	1,033,431	2,539,418	1.129099	1.129099	
56	MEDICAL SUPPLIES CHARGED	676,142		676,142	1.161269	1.161269	
	DRUGS CHARGED TO PATIENTS	816,729		816,729	1.427578	1.427578	
62	OUTPAT SERVICE COST CNTRS						
68	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	195,925		195,925	.587459	.587459	
101	OTHER REIMBURSABLE COST C	29,035,380	1,033,431	30,068,811			
102	SUBTOTAL						
103	LESS OBSERVATION BEDS						
	TOTAL	29,035,380	1,033,431	30,068,811			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
I 26-3303 I FROM 7/ 1/2008 I WORKSHEET C
I I TO 6/30/2009 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 ANCILLARY SRVC COST CNTRS	11,929,405		11,929,405		
41	RADIOLOGY-DIAGNOSTIC	108,219		108,219		
44	LABORATORY	74,820		74,820		
49	RESPIRATORY THERAPY	2,131,529		2,131,529		
50	PHYSICAL THERAPY	2,867,254		2,867,254		
55	MEDICAL SUPPLIES CHARGED	785,183		785,183		
56	DRUGS CHARGED TO PATIENTS	1,165,944		1,165,944		
62	OUTPAT SERVICE COST CNTRS OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS					
68	OTHER REIMBURSABLE COST C	115,098		115,098		
101	SUBTOTAL	19,177,452		19,177,452		
102	LESS OBSERVATION BEDS					
103	TOTAL	19,177,452		19,177,452		

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET C
 I I TO 6/30/2009 I PART I

COMPUTATION OF RATIO OF COSTS TO CHARGES
 SPECIAL TITLE XIX WORKSHEET

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	19,680,818		19,680,818			
41	ANCILLARY SRVC COST CNTRS						
44	RADIOLOGY-DIAGNOSTIC	68,962		68,962	1.569256	1.569256	
49	LABORATORY	206,241		206,241	.362779	.362779	
50	RESPIRATORY THERAPY	5,884,576		5,884,576	.362223	.362223	
55	PHYSICAL THERAPY	1,505,987	1,033,431	2,539,418	1.129099	1.129099	
56	MEDICAL SUPPLIES CHARGED	676,142		676,142	1.161269	1.161269	
62	DRUGS CHARGED TO PATIENTS	816,729		816,729	1.427578	1.427578	
68	OUTPAT SERVICE COST CNTRS						
101	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	195,925		195,925	.587459	.587459	
102	OTHER REIMBURSABLE COST C	29,035,380	1,033,431	30,068,811			
103	SUBTOTAL						
	LESS OBSERVATION BEDS						
	TOTAL	29,035,380	1,033,431	30,068,811			

Health Financial Systems MCRIF32 FOR RANKEN JORDAN
 CALCULATION OF OUTPATIENT SERVICE COST TO
 CHARGE RATIOS NET OF REDUCTIONS

IN LIEU OF FORM CMS-2552-96(09/2000)

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET C
 I I TO 6/30/2009 I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
41	ANCILLARY SRVC COST CNTRS						
	RADIOLOGY-DIAGNOSTIC	108,219	2,263	105,956			108,219
44	LABORATORY	74,820	1,565	73,255			74,820
49	RESPIRATORY THERAPY	2,131,529	170,254	1,961,275			2,131,529
50	PHYSICAL THERAPY	2,867,254	291,228	2,576,026			2,867,254
55	MEDICAL SUPPLIES CHARGED	785,183	141,098	644,085			785,183
56	DRUGS CHARGED TO PATIENTS	1,165,944	24,382	1,141,562			1,165,944
62	OUTPAT SERVICE COST CNTRS						
	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
68	OTHER REIMBURSABLE COST C	115,098	2,407	112,691			115,098
101	SUBTOTAL	7,248,047	633,197	6,614,850			7,248,047
102	LESS OBSERVATION BEDS						
103	TOTAL	7,248,047	633,197	6,614,850			7,248,047

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
41	ANCILLARY SRVC COST CNTRS	68,962	1.569256	1.569256
44	RADIOLOGY-DIAGNOSTIC	206,241	.362779	.362779
49	LABORATORY	5,884,576	.362223	.362223
50	RESPIRATORY THERAPY	2,539,418	1.129099	1.129099
55	PHYSICAL THERAPY	676,142	1.161269	1.161269
56	MEDICAL SUPPLIES CHARGED	816,729	1.427578	1.427578
62	DRUGS CHARGED TO PATIENTS			
	OUTPAT SERVICE COST CNTRS			
	OBSERVATION BEDS (NON-DIS			
68	OTHER REIMBURS COST CNTRS	195,925	.587459	.587459
101	SUBTOTAL	10,387,993		
102	LESS OBSERVATION BEDS			
103	TOTAL	10,387,993		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
41	ANCILLARY SRVC COST CNTRS						
	RADIOLOGY-DIAGNOSTIC	108,219	2,263	105,956			108,219
44	LABORATORY	74,820	1,565	73,255			74,820
49	RESPIRATORY THERAPY	2,131,529	170,254	1,961,275			2,131,529
50	PHYSICAL THERAPY	2,867,254	291,228	2,576,026			2,867,254
55	MEDICAL SUPPLIES CHARGED	785,183	141,098	644,085			785,183
56	DRUGS CHARGED TO PATIENTS	1,165,944	24,382	1,141,562			1,165,944
62	OUTPAT SERVICE COST CNTRS						
	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
68	OTHER REIMBURSABLE COST C	115,098	2,407	112,691			115,098
101	SUBTOTAL	7,248,047	633,197	6,614,850			7,248,047
102	LESS OBSERVATION BEDS						
103	TOTAL	7,248,047	633,197	6,614,850			7,248,047

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
41	ANCILLARY SRVC COST CNTRS			
	RADIOLOGY-DIAGNOSTIC	68,962	1.569256	1.569256
44	LABORATORY	206,241	.362779	.362779
49	RESPIRATORY THERAPY	5,884,576	.362223	.362223
50	PHYSICAL THERAPY	2,539,418	1.129099	1.129099
55	MEDICAL SUPPLIES CHARGED	676,142	1.161269	1.161269
56	DRUGS CHARGED TO PATIENTS	816,729	1.427578	1.427578
62	OUTPAT SERVICE COST CNTRS			
	OBSERVATION BEDS (NON-DIS			
	OTHER REIMBURS COST CNTRS			
68	OTHER REIMBURSABLE COST C	195,925	.587459	.587459
101	SUBTOTAL	10,387,993		
102	LESS OBSERVATION BEDS			
103	TOTAL	10,387,993		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET D
 I I TO 6/30/2009 I PART I
 TEFRA

TITLE XVIII, PART A

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
		CAPITAL REL COST (B, II) 1	SWING BED ADJUSTMENT 2	REDUCED CAP RELATED COST 3	CAPITAL REL COST (B, III) 4	SWING BED ADJUSTMENT 5	REDUCED CAP RELATED COST 6
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS				1,897,003		1,897,003
101	TOTAL				1,897,003		1,897,003

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET D
 I I TO 6/30/2009 I PART I
 TEFRA

TITLE XVIII, PART A

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	INPAT PROGRAM OLD CAP CST 10	NEW CAPITAL PER DIEM 11	INPAT PROGRAM NEW CAP CST 12
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	10,863				174.63	
101	TOTAL	10,863					

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

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET D
 I I TO 6/30/2009 I PART III
 TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	MED EDUCATN COST 2	SWING BED ADJ AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS					10,863	
101	TOTAL					10,863	

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

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
I 26-3303 I FROM 7/ 1/2008 I WORKSHEET D
I I TO 6/30/2009 I PART III

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2009 I PART V
 I 26-3303 I I

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic	All other (1)
	1	2	3	4	5
(A) ANCILLARY SRVC COST CNTRS					
41 RADIOLOGY-DIAGNOSTIC	1.569256				
44 LABORATORY	.362779				
49 RESPIRATORY THERAPY	.362223				
50 PHYSICAL THERAPY	1.129099				323,046
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.161269				
56 DRUGS CHARGED TO PATIENTS	1.427578				
62 OUTPAT SERVICE COST CNTRS					
OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURS COST CNTRS					
68 OTHER REIMBURSABLE COST CENTERS	.587459				
101 SUBTOTAL					323,046
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					323,046

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2009 I PART V
 I 26-3303 I I

TITLE XIX - O/P

HOSPITAL

PPS Services
FYB to 12/31

Non-PPS
Services

PPS Services
1/1 to FYE

Outpatient
Ambulatory
Surgical Ctr

Outpatient
Radiology

Cost Center Description

5.01

5.02

5.03

6

7

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

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2009 I PART V
 I 26-3303 I I

TITLE XIX - O/P

HOSPITAL

	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
Cost Center Description	8	9	9.01	9.02	9.03
(A) ANCILLARY SRVC COST CNTRS					
41 RADIOLOGY-DIAGNOSTIC					
44 LABORATORY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY		364,751			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56 DRUGS CHARGED TO PATIENTS					
62 OUTPAT SERVICE COST CNTRS					
OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURS COST CNTRS					
68 OTHER REIMBURSABLE COST CENTERS					
101 SUBTOTAL		364,751			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		364,751			

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 6/30/2009 I PART I
 I 26-3303 I I

TITLE XVIII PART A HOSPITAL TEFRA

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	10,863
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	10,863
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	10,863
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)	
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	11,929,405
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	11,929,405

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	19,553,400
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	19,553,400
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.610094
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,800.00
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	11,929,405

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 6/30/2009 I PART II
 I 26-3303 I I

TITLE XVIII PART A HOSPITAL TEFRA

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 1,098.17
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST

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

1

48 PROGRAM INPATIENT ANCILLARY SERVICE COST
 49 TOTAL PROGRAM INPATIENT COSTS

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 28,574.05
 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

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 6/30/2009 I PART III
 I 26-3303 I I

COMPUTATION OF INPATIENT OPERATING COST

TITLE XVIII PART A HOSPITAL TEFRA

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 1,098.17
- 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		11,929,405			
87 NEW CAPITAL-RELATED COST	1,897,003	11,929,405	.159019		
88 NON PHYSICIAN ANESTHETIST		11,929,405			
89 MEDICAL EDUCATION		11,929,405			
89.01 MEDICAL EDUCATION - ALLIED HEA					
89.02 MEDICAL EDUCATION - ALL OTHER					

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 6/30/2009 I PART I
 I 26-3303 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)	10,863
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	10,863
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	10,863
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)	5,151
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	11,929,405
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	11,929,405

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	19,553,400
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	19,553,400
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.610094
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,800.00
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	11,929,405

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 6/30/2009 I PART II
 I 26-3303 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 1,098.17
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 5,656,674
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 5,656,674

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
44 INTENSIVE CARE UNIT					
45 CORONARY CARE UNIT					
46 BURN INTENSIVE CARE UNIT					
47 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					1
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					3,138,383
49 TOTAL PROGRAM INPATIENT COSTS					8,795,057

PASS THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 6/30/2009 I PART III
 I 26-3303 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 1,098.17
- 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 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET D-4
 I COMPONENT NO: I TO 6/30/2009 I
 I 26-3303 I

WKST A LINE NO.	COST CENTER DESCRIPTION	HOSPITAL	OTHER		
			RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			9,328,173	
41	ANCILLARY SRVC COST CNTRS				
44	RADIOLOGY-DIAGNOSTIC		1.569256	34,907	54,778
49	LABORATORY		.362779	95,509	34,649
50	RESPIRATORY THERAPY		.362223	3,146,270	1,139,651
55	PHYSICAL THERAPY		1.129099	716,373	808,856
56	MEDICAL SUPPLIES CHARGED TO PATIENTS		1.161269	349,128	405,432
62	DRUGS CHARGED TO PATIENTS		1.427578	441,446	630,199
68	OUTPAT SERVICE COST CNTRS				
101	OBSERVATION BEDS (NON-DISTINCT PART)				
102	OTHER REIMBURSABLE COST CNTRS				
103	OTHER REIMBURSABLE COST CENTERS		.587459	110,336	64,818
	TOTAL			4,893,969	3,138,383
	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES				
	NET CHARGES			4,893,969	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET E-3
 I COMPONENT NO: I TO 6/30/2009 I PART III
 I - I I

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				
2			8,795,057	
3			364,751	
4				
5				
6			9,159,808	
7				
8				
9			9,159,808	
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
10			9,271,800	
11			5,217,015	
12				
13				
14				
15				
16			14,488,815	
	CUSTOMARY CHARGES			
17				
18				
19				
20			14,488,815	
21			5,329,007	
22				
23			9,159,808	
	PROSPECTIVE PAYMENT AMOUNT			
24				
25				
26				
27				
28				
29				
30			9,159,808	
31				
32			9,159,808	
33				
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34				
35			9,159,808	
36				
37				
38				
38.01				
38.02				
38.03				
39				
40			9,159,808	
41				
42				
43				
44				
45				
46				
47				
48				
49				
50				
51				
52			9,159,808	
53				
54				
55			9,159,808	
56				
57			7,270,320	
57.01				
58			1,889,488	
59				

CALCULATION OF REIMBURSEMENT SETTLEMENT

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.

	IN LIEU OF FORM CMS-2552-96-E-3 (5/2008)		
I	PROVIDER NO:	I PERIOD:	I PREPARED 10/29/2009
I	26-3303	I FROM 7/ 1/2008	I WORKSHEET E-3
I	COMPONENT NO:	I TO 6/30/2009	I PART III
I	-	I	I

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I
 I TO 6/30/2009 I WORKSHEET G

	GENERAL FUND	SPECIFIC FUND PURPOSE	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	1,384,351			
2 TEMPORARY INVESTMENTS	502,752			
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	2,449,865			
5 OTHER RECEIVABLES	39,862			
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7 INVENTORY				
8 PREPAID EXPENSES	261,097			
9 OTHER CURRENT ASSETS				
10 DUE FROM OTHER FUNDS				
11 TOTAL CURRENT ASSETS	4,637,927			
FIXED ASSETS				
12 LAND	2,359,177			
12.01 LAND IMPROVEMENTS				
13.01 LESS ACCUMULATED DEPRECIATION				
14 BUILDINGS	19,873,426			
14.01 LESS ACCUMULATED DEPRECIATION	-2,208,365			
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	3,470,675			
18.01 LESS ACCUMULATED DEPRECIATION	-1,301,540			
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE				
21 TOTAL FIXED ASSETS	22,193,373			
OTHER ASSETS				
22 INVESTMENTS	6,664,904			
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS	13,870,376			
26 TOTAL OTHER ASSETS	20,535,280			
27 TOTAL ASSETS	47,366,580			

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I
 I I TO 6/30/2009 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	203,207			
29 SALARIES, WAGES & FEES PAYABLE				
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	430,600			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	1,178,156			
36 TOTAL CURRENT LIABILITIES	1,811,963			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE	20,468,060			
38 NOTES PAYABLE				
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES				
42 TOTAL LONG-TERM LIABILITIES	20,468,060			
43 TOTAL LIABILITIES	22,280,023			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	25,086,557			
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	25,086,557			
52 TOTAL LIABILITIES AND FUND BALANCES	47,366,580			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		20,845,953		
2 NET INCOME (LOSS)		4,379,515		
3 TOTAL		25,225,468		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 INCREASE IN TEMPORARILY R	51,981			
6				
7				
8				
9				
10 TOTAL ADDITIONS		51,981		
11 SUBTOTAL		25,277,449		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 NET ASSETS RELEASED FROM	190,892			
14				
15				
16				
17				
18 TOTAL DEDUCTIONS		190,892		
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		25,086,557		

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET G-2
 I I TO 6/30/2009 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	19,553,400		19,553,400
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	19,553,400		19,553,400
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	19,553,400		19,553,400
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	19,553,400		19,553,400
17 00 ANCILLARY SERVICES	9,481,980		9,481,980
18 00 OUTPATIENT SERVICES		1,033,431	1,033,431
24 00 PHYSICIAN PRO FEES	240,547		240,547
25 00 TOTAL PATIENT REVENUES	29,275,927	1,033,431	30,309,358

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		20,691,122	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		20,691,122	

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 10/29/2009
 I 26-3303 I FROM 7/ 1/2008 I WORKSHEET G-3
 I I TO 6/30/2009 I

DESCRIPTION		
1	TOTAL PATIENT REVENUES	30,309,358
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	5,691,230
3	NET PATIENT REVENUES	24,618,128
4	LESS: TOTAL OPERATING EXPENSES	20,691,122
5	NET INCOME FROM SERVICE TO PATIENTS	3,927,006
OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	1,716,683
7	INCOME FROM INVESTMENTS	100,331
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	10,098
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	GRANT INCOME	38,032
24.01	MISCELLANEOUS REVENUE	17,886
25	TOTAL OTHER INCOME	1,883,030
26	TOTAL	5,810,036
OTHER EXPENSES		
27	INVESTMENT LOSS	1,430,521
28		
29		
30	TOTAL OTHER EXPENSES	1,430,521
31	NET INCOME (OR LOSS) FOR THE PERIOD	4,379,515