IN LIEU OF FORM CMS-2552-96(04/2005)
PREPARED 5/28/2010 13:19
FORM APPROVED
OMB NO. 0938-0050

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

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 26-4012	PERIOD FROM 9/ 1/2009 TO 12/31/2009	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 5/28/2010 TIME 13:19

PART I - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
CENTERPOINTE HOSPITAL 26-4012
FOR THE COST REPORTING PERIOD BEGINNING 9/ 1/2009 AND ENDING 12/31/2009 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

Susan M Mathis
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

Chief Operating Officer
TITLE

5-28-10
DATE

ECR ENCRYPTION INFORMATION
DATE: 5/28/2010 TIME 13:19
RkUdJsCKWAz6Epn7wTwyqAupexQ.U0YLayG0qDLcvQdz3EL6zHpf6ZPWAk8moR1u0vxl1l0pnQ7l

PI ENCRYPTION INFORMATION
DATE: 5/28/2010 TIME 13:19
BIS5SwQpR4LFDUsKqRjKLXOZkiGKPOQ9qaQ0A9fI9s:GJIgGqFZIPJapqCkOq83.2N23OR0I1Ddy

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII A	TITLE XVIII B	TITLE XIX
		1	2	3	4
1	HOSPITAL	0	12,938	30,740	435,658
100	TOTAL	0	12,938	30,740	435,658

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.

IN LIEU OF FORM CMS-2552-96(04/2005)
PREPARED 5/28/2010 13:10
FORM APPROVED
OMB NO. 0938-0050

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

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 26-4012	PERIOD FROM 9/ 1/2009 TO 12/31/2009	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 5/28/2010 TIME 13:10

PART I - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
CENTERPOINTE HOSPITAL 26-4012
FOR THE COST REPORTING PERIOD BEGINNING 9/ 1/2009 AND ENDING 12/31/2009 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

Susan Mathis
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

Chief Operating Officer
TITLE

5-28-10
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII A	TITLE XVIII B	TITLE XIX
		1	2	3	4
1	HOSPITAL	0	12,938	30,740	435,658
100	TOTAL	0	12,938	30,740	435,658

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.

IN LIEU OF FORM CMS-2552-96(04/2005)
PREPARED 5/28/2010 13:10
FORM APPROVED
OMB NO. 0938-0050

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

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 26-4012	PERIOD FROM 9/ 1/2009 TO 12/31/2009	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 5/28/2010 TIME 13:10

PART I - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
CENTERPOINTE HOSPITAL 26-4012
FOR THE COST REPORTING PERIOD BEGINNING 9/ 1/2009 AND ENDING 12/31/2009 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII A	TITLE XVIII B	TITLE XIX
		1	2	3	4
1	HOSPITAL	0	12,938	30,740	435,658
100	TOTAL	0	12,938	30,740	435,658

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: 26-4012 I PERIOD: I FROM 9/ 1/2009 I TO 12/31/2009 I PREPARED 5/28/2010 I WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 5931 HIGHWAY 94 SOUTH P.O. BOX:
1.01 CITY: ST. CHARLES STATE: MO ZIP CODE: 63304- COUNTY: ST CHARLES

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

	COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX
	0	1	2	2.01	3	4	5	6
02.00	HOSPITAL	CENTERPOINTE HOSPITAL	26-4012		4/ 1/2003	N	P	O

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 9/ 1/2009 TO: 12/31/2009

		1	2
18	TYPE OF CONTROL	4	

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	4	
20	SUBPROVIDER		

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.	1	Y
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.	N	
21.02	HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).		
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	1	N N 41180
21.04	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	1	
21.05	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	1	
21.06	DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105 OR MIPPA §147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO.	N	
21.07	DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)	N	
21.08	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEEDING COST REPORTING PERIOD? ENTER IN COLUMN 2, "Y" FOR YES OR "N" FOR NO.		
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?	N
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	N
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	N
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	N
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)	N
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH),ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /	
26.02	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /	
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	N / /
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02	

		1	2	3	4
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)	0	0.0000	0.0000	
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	0.00	0		

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

		%	Y/N
28.03	STAFFING	0.00%	
28.04	RECRUITMENT	0.00%	
28.05	RETENTION	0.00%	
28.06	TRAINING	0.00%	

29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	N
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)	N
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70	
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)	
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).	N
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II	N
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N

MISCELLANEOUS COST REPORT INFORMATION

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

		V	XVIII	XIX
	PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL	1	2	3
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS)	N	N	N
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?	N	N	N
	TITLE XIX INPATIENT SERVICES			
38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	Y		
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	Y		
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	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 CHAIN NUMBER. (SEE INSTRUCTIONS).	N		
40.01	NAME: FI/CONTRACTOR NAME FI/CONTRACTOR #			
40.02	STREET: P.O. BOX:			
40.03	CITY: STATE: ZIP CODE: -			
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY?	N		
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.	N	00/00/0000	
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?			
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?			
45.03	WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?			
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).			

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

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

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS)	N
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV	N
53	IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0
53.01	MDH PERIOD: BEGINNING: / / ENDING: / /	
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:	
	PREMIUMS: 12,000	
	PAID LOSSES: 0	
	AND/OR SELF INSURANCE: 0	
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.	N

		DATE 0	Y OR N 1	LIMIT 2	Y OR N 3	FEES 4
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		N	0.00		0
56.01	ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02	THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03	FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?		N			
58	ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.		N			
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y"FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).					
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)		N			
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)		Y	N		
60.01	IF LINE 60 COLUMN 1 IS Y, 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? N
ENTER "Y" FOR YES AND "N" FOR NO.

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

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00						0.00

SETTLEMENT DATA

63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). Y 3/ 1/2010

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

PROVIDER NO: 26-4012 | PERIOD: FROM 9/ 1/2009 TO 12/31/2009 | PREPARED 5/28/2010 | WORKSHEET S-3 PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH N/A 2.01	I/P DAYS / O/P VISITS / TRIPS TITLE V 3	TITLE XVIII 4	NOT LTCH N/A 4.01	TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	83	10,126			1,973		1,661
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	83	10,126			1,973		1,661
10	CHEMICAL DEPENDENCY UNIT	14	1,708					
12	TOTAL	97	11,834			1,973		1,661
13	RPCH VISITS							
25	TOTAL	97						
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I/P DAYS / O/P VISITS / TRIPS TITLE XIX ADMITTED 5.01	OBSERVATION BEDS NOT ADMITTED 5.02	TOTAL ALL PATS 6	TOTAL OBSERVATION BEDS ADMITTED 6.01	NOT ADMITTED 6.02	INTERNS & RES. FTES TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			8,013				
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS			8,013				
10	CHEMICAL DEPENDENCY UNIT			1,148				
12	TOTAL			9,161				
13	RPCH VISITS							
25	TOTAL							
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I & R FTES NET 9	FULL TIME EQUIV EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	DISCHARGES TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS					167	116	939
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
10	CHEMICAL DEPENDENCY UNIT							
12	TOTAL		278.70			167	116	939
13	RPCH VISITS							
25	TOTAL		278.70					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 26-4012 I PERIOD: I FROM 9/ 1/2009 I TO 12/31/2009 I PREPARED 5/28/2010 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT				363,136	363,136
3.01	0301	NEW CAP REL COSTS-BLDG & FIXT					
4	0400	NEW CAP REL COSTS-MVBLE EQUIP				231,182	231,182
5	0500	EMPLOYEE BENEFITS	53,090	1,134,693	1,187,783	-1,096	1,186,687
6	0600	ADMINISTRATIVE & GENERAL	974,836	1,272,836	2,247,672	-325,341	1,922,331
7	0700	MAINTENANCE & REPAIRS	61,889	118,813	180,702	-3,789	176,913
9	0900	LAUNDRY & LINEN SERVICE		27,344	27,344		27,344
10	1000	HOUSEKEEPING		86,561	86,561		86,561
11	1100	DIETARY	92,151	213,711	305,862		305,862
12	1200	CAFETERIA					
14	1400	NURSING ADMINISTRATION	227,197	19,342	246,539	-2,633	243,906
16	1600	PHARMACY					
17	1700	MEDICAL RECORDS & LIBRARY	77,180	68,065	145,245	-15,576	129,669
18	1800	SOCIAL SERVICE	146,709	1,047	147,756	-24	147,732
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	1,683,592	419,171	2,102,763	10,154	2,112,917
30	0000	CHEMICAL DEPENDENCY UNIT	162,348	57,265	219,613	3,880	223,493
		ANCILLARY SRVC COST CNTRS					
41	4100	RADIOLOGY-DIAGNOSTIC		13,864	13,864	-13,864	
44	4400	LABORATORY		34,456	34,456	-34,456	
54	5400	ELECTROENCEPHALOGRAPHY				34,356	34,356
56	5600	DRUGS CHARGED TO PATIENTS	4,784	132,370	137,154		137,154
		OUTPAT SERVICE COST CNTRS					
60	6000	CLINIC	1,128,799	439,644	1,568,443	-239,687	1,328,756
		SPEC PURPOSE COST CENTERS					
88	8800	INTEREST EXPENSE					
90	9000	OTHER CAPITAL RELATED COSTS		45,033	45,033	-45,033	
95		SUBTOTALS	4,612,575	4,084,215	8,696,790	-38,791	8,657,999
		NONREIMBURS COST CENTERS					
97	9700	RESEARCH					
100	7950	OTHER NONREIMBURSABLE COST CENTERS				38,791	38,791
101		TOTAL	4,612,575	4,084,215	8,696,790	-0-	8,696,790

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I 26-4012 I
I PERIOD: I FROM 9/ 1/2009 I TO 12/31/2009 I
I PREPARED 5/28/2010 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
			6	7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT	-557	362,579
3.01	0301	NEW CAP REL COSTS-BLDG & FIXT		
4	0400	NEW CAP REL COSTS-MVBLE EQUIP	-28,313	202,869
5	0500	EMPLOYEE BENEFITS	-14,634	1,172,053
6	0600	ADMINISTRATIVE & GENERAL	-246,256	1,676,075
7	0700	MAINTENANCE & REPAIRS		176,913
9	0900	LAUNDRY & LINEN SERVICE		27,344
10	1000	HOUSEKEEPING		86,561
11	1100	DIETARY	-10,257	295,605
12	1200	CAFETERIA		
14	1400	NURSING ADMINISTRATION		243,906
16	1600	PHARMACY		
17	1700	MEDICAL RECORDS & LIBRARY	-1,601	128,068
18	1800	SOCIAL SERVICE		147,732
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS	-281,149	1,831,768
30	0000	CHEMICAL DEPENDENCY UNIT	-44,050	179,443
		ANCILLARY SRVC COST CNTRS		
41	4100	RADIOLOGY-DIAGNOSTIC		
44	4400	LABORATORY		
54	5400	ELECTROENCEPHALOGRAPHY		34,356
56	5600	DRUGS CHARGED TO PATIENTS		137,154
		OUTPAT SERVICE COST CNTRS		
60	6000	CLINIC	-159,218	1,169,538
		SPEC PURPOSE COST CENTERS		
88	8800	INTEREST EXPENSE		-0-
90	9000	OTHER CAPITAL RELATED COSTS		-0-
95		SUBTOTALS	-786,035	7,871,964
		NONREIMBURS COST CENTERS		
97	9700	RESEARCH		
100	7950	OTHER NONREIMBURSABLE COST CENTERS		38,791
101		TOTAL	-786,035	7,910,755

COST CENTERS USED IN COST REPORT

I PROVIDER NO: 26-4012 I PERIOD: I FROM 9/ 1/2009 I TO 12/31/2009 I PREPARED 5/28/2010 I NOT A CMS WORKSHEET

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
3.01	NEW CAP REL COSTS-BLDG & FIXT	0301	NEW CAP REL COSTS-BLDG & FIXT
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
30	CHEMICAL DEPENDENCY UNIT	0000	
	ANCILLARY SRVC COST		
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
54	ELECTROENCEPHALOGRAPHY	5400	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
60	CLINIC	6000	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
97	RESEARCH	9700	
100	OTHER NONREIMBURSABLE COST CENTERS	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED 5/28/2010
264012	FROM 9/ 1/2009	WORKSHEET A-6
	TO 12/31/2009	

	EXPLANATION OF RECLASSIFICATION	CODE (1) 1	COST CENTER 2	INCREASE LINE NO 3	SALARY 4	OTHER 5
1	RECLASS POSTAGE & TELEPHONE TO A&G	A				
2						
3						
4						
5			ADMINISTRATIVE & GENERAL	6		9,668
6	RECLASS RENTAL & LEASE EXP.	B	NEW CAP REL COSTS-BLDG & FIXT	3		334,293
7			NEW CAP REL COSTS-MVBLE EQUIP	4		58,636
8						
9						
10						
11						
12						
13						
14						
15	RECLASS LAB COSTS TO ROUTINE	C	ADULTS & PEDIATRICS	25		31,689
16			CHEMICAL DEPENDENCY UNIT	30		2,767
17	TO RECLASS COMMUNITY RECLASS MKTING	D	OTHER NONREIMBURSABLE COST CENTERS	100	22,775	16,016
18	RECLASS BLDG & LEASEHOLD IMPROVEMENT	E	NEW CAP REL COSTS-BLDG & FIXT	3		15,854
19			NEW CAP REL COSTS-MVBLE EQUIP	4		113,187
20	TO RECLASS PROPERTY TAX	F	NEW CAP REL COSTS-BLDG & FIXT	3		7,898
21			NEW CAP REL COSTS-MVBLE EQUIP	4		35,186
22	RECLASS OF LIGHT DUTY WAGES FROM A&G	G	ADULTS & PEDIATRICS	25	76	
23	TO RECLASS ECT COSTS FROM A&P	H	ELECTROENCEPHALOGRAPHY	54		34,356
24	TO RECLASS INT EXP & INT LT DEBT	I	NEW CAP REL COSTS-BLDG & FIXT	3		281
25			NEW CAP REL COSTS-MVBLE EQUIP	4		1,253
26			ADMINISTRATIVE & GENERAL	6		415
27	TO RECLASS LIABILITY & AUTO INS.	J	NEW CAP REL COSTS-BLDG & FIXT	3		4,810
28			NEW CAP REL COSTS-MVBLE EQUIP	4		22,920
29	TO RECLASS DRIVERS A&G TIME	K	ADMINISTRATIVE & GENERAL	6	68,396	
30	RECLASS RADIOLOGY RECLASS	L	ADULTS & PEDIATRICS	25		12,751
31			CHEMICAL DEPENDENCY UNIT	30		1,113
36	TOTAL RECLASSIFICATIONS				91,247	703,093

(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
264012	FROM 9/ 1/2009	5/28/2010
	TO 12/31/2009	WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE LINE NO	SALARY	OTHER	A-7 REF
		1	6	7	8	9	10
1	RECLASS POSTAGE & TELEPHONE TO A&G	A	EMPLOYEE BENEFITS	5		24	
2			MEDICAL RECORDS & LIBRARY	17		286	
3			SOCIAL SERVICE	18		24	
4			CLINIC	60		9,334	
5							
6	RECLASS RENTAL & LEASE EXP.	B					10
7							10
8			EMPLOYEE BENEFITS	5		1,072	10
9			ADMINISTRATIVE & GENERAL	6		208,182	10
10			MAINTENANCE & REPAIRS	7		3,789	10
11			NURSING ADMINISTRATION	14		2,633	10
12			MEDICAL RECORDS & LIBRARY	17		15,290	10
13			ADULTS & PEDIATRICS	25		6	10
14			CLINIC	60		161,957	10
15	RECLASS LAB COSTS TO ROUTINE	C	LABORATORY	44		34,456	
16							
17	TO RECLASS COMMUNITY RECLASS MKTING	D	ADMINISTRATIVE & GENERAL	6	22,775	16,016	
18	RECLASS BLDG & LEASEHOLD IMPROVEMENT	E	ADMINISTRATIVE & GENERAL	6		129,041	10
19							10
20	TO RECLASS PROPERTY TAX	F	OTHER CAPITAL RELATED COSTS	90		43,084	9
21							9
22	RECLASS OF LIGHT DUTY WAGES FROM A&G	G	ADMINISTRATIVE & GENERAL	6	76		
23	TO RECLASS ECT COSTS FROM A&P	H	ADULTS & PEDIATRICS	25		34,356	
24	TO RECLASS INT EXP & INT LT DEBT	I	OTHER CAPITAL RELATED COSTS	90		1,534	9
25							9
26			OTHER CAPITAL RELATED COSTS	90		415	9
27	TO RECLASS LIABILITY & AUTO INS.	J	ADMINISTRATIVE & GENERAL	6		27,730	9
28							9
29	TO RECLASS DRIVERS A&G TIME	K	CLINIC	60	68,396		
30	RECLASS RADIOLOGY RECLASS	L	RADIOLOGY-DIAGNOSTIC	41		13,864	
31							
36	TOTAL RECLASSIFICATIONS				91,247	703,093	

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

RECLASS CODE: A
EXPLANATION : RECLASS POSTAGE & TELEPHONE TO A&G

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00			0	EMPLOYEE BENEFITS	5	24
2.00			0	MEDICAL RECORDS & LIBRARY	17	286
3.00			0	SOCIAL SERVICE	18	24
4.00			0	CLINIC	60	9,334
5.00	ADMINISTRATIVE & GENERAL	6	9,668			0
TOTAL RECLASSIFICATIONS FOR CODE A			9,668			9,668

RECLASS CODE: B
EXPLANATION : RECLASS RENTAL & LEASE EXP.

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	334,293			0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	58,636			0
3.00			0	EMPLOYEE BENEFITS	5	1,072
4.00			0	ADMINISTRATIVE & GENERAL	6	208,182
5.00			0	MAINTENANCE & REPAIRS	7	3,789
6.00			0	NURSING ADMINISTRATION	14	2,633
7.00			0	MEDICAL RECORDS & LIBRARY	17	15,290
8.00			0	ADULTS & PEDIATRICS	25	6
9.00			0	CLINIC	60	161,957
TOTAL RECLASSIFICATIONS FOR CODE B			392,929			392,929

RECLASS CODE: C
EXPLANATION : RECLASS LAB COSTS TO ROUTINE

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADULTS & PEDIATRICS	25	31,689	LABORATORY	44	34,456
2.00	CHEMICAL DEPENDENCY UNIT	30	2,767			0
TOTAL RECLASSIFICATIONS FOR CODE C			34,456			34,456

RECLASS CODE: D
EXPLANATION : TO RECLASS COMMUNITY RECLASS MKTING

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OTHER NONREIMBURSABLE COST CEN	100	38,791	ADMINISTRATIVE & GENERAL	6	38,791
TOTAL RECLASSIFICATIONS FOR CODE D			38,791			38,791

RECLASS CODE: E
EXPLANATION : RECLASS BLDG & LEASEHOLD IMPROVEMENT

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	15,854	ADMINISTRATIVE & GENERAL	6	129,041
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	113,187			0
TOTAL RECLASSIFICATIONS FOR CODE E			129,041			129,041

RECLASS CODE: F
EXPLANATION : TO RECLASS PROPERTY TAX

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	7,898	OTHER CAPITAL RELATED COSTS	90	43,084
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	35,186			0
TOTAL RECLASSIFICATIONS FOR CODE F			43,084			43,084

RECLASS CODE: G
EXPLANATION : RECLASS OF LIGHT DUTY WAGES FROM A&G

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADULTS & PEDIATRICS	25	76	ADMINISTRATIVE & GENERAL	6	76
TOTAL RECLASSIFICATIONS FOR CODE G			76			76

RECLASS CODE: H
EXPLANATION : TO RECLASS ECT COSTS FROM A&P

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ELECTROENCEPHALOGRAPHY	54	34,356	ADULTS & PEDIATRICS	25	34,356
TOTAL RECLASSIFICATIONS FOR CODE H			34,356			34,356

RECLASS CODE: I
EXPLANATION : TO RECLASS INT EXP & INT LT DEBT

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	281	OTHER CAPITAL RELATED COSTS	90	1,534
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	1,253			0
3.00	ADMINISTRATIVE & GENERAL	6	415	OTHER CAPITAL RELATED COSTS	90	415
TOTAL RECLASSIFICATIONS FOR CODE I			1,949			1,949

RECLASS CODE: J
EXPLANATION : TO RECLASS LIABILITY & AUTO INS.

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	4,810	ADMINISTRATIVE & GENERAL	6	27,730
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	22,920			0
TOTAL RECLASSIFICATIONS FOR CODE J			27,730			27,730

RECLASS CODE: K
EXPLANATION : TO RECLASS DRIVERS A&G TIME

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	68,396	CLINIC	60	68,396
TOTAL RECLASSIFICATIONS FOR CODE K			68,396			68,396

RECLASS CODE: L
EXPLANATION : RECLASS RADIOLOGY RECLASS

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADULTS & PEDIATRICS	25	12,751	RADIOLOGY-DIAGNOSTIC	41	13,864
2.00	CHEMICAL DEPENDENCY UNIT	30	1,113			0
TOTAL RECLASSIFICATIONS FOR CODE L			13,864			13,864

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASES 2	DONATION 3	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN	475,620	41,483		41,483		517,103	
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	2,187,615	116,016		116,016		2,303,631	
7	SUBTOTAL	2,663,235	157,499		157,499		2,820,734	
8	RECONCILING ITEMS							
9	TOTAL	2,663,235	157,499		157,499		2,820,734	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
	GROSS ASSETS	CAPITLIZED GROSS ASSETS LEASES	FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	TOTAL
*	1	2	3	4	5	6	7	8
3 NEW CAP REL COSTS-BL								
3 01 NEW CAP REL COSTS-BL								
4 NEW CAP REL COSTS-MV								
5 TOTAL				1.000000				

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*	9	10	11	12	13	14	15
3 NEW CAP REL COSTS-BL	12,432	350,147					362,579
3 01 NEW CAP REL COSTS-BL							
4 NEW CAP REL COSTS-MV	59,359	143,510					202,869
5 TOTAL	71,791	493,657					565,448

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

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*	9	10	11	12	13	14	15
3 NEW CAP REL COSTS-BL							
3 01 NEW CAP REL COSTS-BL							
4 NEW CAP REL COSTS-MV							
5 TOTAL							

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: 26-4012 I PERIOD: I FROM 9/ 1/2009 I TO 12/31/2009 I PREPARED 5/28/2010 I WORKSHEET A-8

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST. A-7 REF. 5
1	INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5	INVESTMENT INCOME-OTHER	B	-557	NEW CAP REL COSTS-BLDG &	3	9
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	-648,651			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS	B	-10,257	DIETARY	11	
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-1,601	MEDICAL RECORDS & LIBRARY	17	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES	B	-2,300	ADMINISTRATIVE & GENERAL	6	
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		**COST CENTER DELETED**	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		**COST CENTER DELETED**	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37	LOBBYING ADJUSTMENT MHA DUES	A	-2,518	ADMINISTRATIVE & GENERAL	6	
38						
39	DRIVERS TRANSPORTING PATIENTS	A	-68,396	CLINIC	60	
40	DRIVERS TRANSPORTING PATIENTS BENES	A	-14,158	EMPLOYEE BENEFITS	5	
41	DRIVERS TRANSPORTING PATIENTS DEPR	A	-28,313	NEW CAP REL COSTS-MVBLE E	4	10
42	OTHER INCOME	B	-14,961	ADMINISTRATIVE & GENERAL	6	
43	FRA	A	380,896	ADMINISTRATIVE & GENERAL	6	
44	TRANSPORTATION HOSPITAL WAGES	A	-6,225	ADMINISTRATIVE & GENERAL	6	
45	TRANSPORTATION HOSPITAL OTHER	A	-135,501	ADMINISTRATIVE & GENERAL	6	
46	TRANSPORTATION HOSPITAL	A	-476	EMPLOYEE BENEFITS	5	
47	BAD DEBTS	A	-233,017	ADMINISTRATIVE & GENERAL	6	
48	OTHER ADJUSTMENTS (SPECIFY)					
49	OTHER ADJUSTMENTS (SPECIFY)					
50	TOTAL (SUM OF LINES 1 THRU 49)		-786,035			

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 26-4012 I PERIOD: I FROM 9/ 1/2009 I TO 12/31/2009 I PREPARED 5/28/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN-ERATION 3	PROFES-SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	6	MEDICAL STAFF PHYSICIANS	232,630	232,630					
2	25	ADULTS & PEDS	281,149	281,149					
3	30	CHEMICAL DEPENDENCY PHYSI	44,050	44,050					
4	60	CLINIC PHYSICIAN	90,822	90,822					
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	648,651	648,651					

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 26-4012 I PERIOD: I FROM 9/ 1/2009 I TO 12/31/2009 I PREPARED 5/28/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11	COST OF MEMBERSHIPS & CONTINUING EDUCATION 12	PROVIDER COMPONENT SHARE OF COL 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COL 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUSTMENT 18
1	6	MEDICAL STAFF PHYSICIANS							232,630
2	25	ADULTS & PEDS							281,149
3	30	CHEMICAL DEPENDENCY PHYSI							44,050
4	60	CLINIC PHYSICIAN							90,822
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							648,651

COST ALLOCATION STATISTICS

I PROVIDER NO: I 26-4012 I
I PERIOD: I FROM 9/ 1/2009 I TO 12/31/2009 I
I PREPARED 5/28/2010 I NOT A CMS WORKSHEET I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE FEET	ENTERED
3.01	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
9	LAUNDRY & LINEN SERVICE	1	PATIENT DAYS	ENTERED
10	HOUSEKEEPING	3	SQUARE FEET	ENTERED
11	DIETARY	10	MEALS SERVED	ENTERED
12	CAFETERIA	2	PAID FTE'S	ENTERED
14	NURSING ADMINISTRATION	1	PATIENT DAYS	ENTERED
16	PHARMACY	9	PERCENT	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	ENTERED
18	SOCIAL SERVICE	17	TIME SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER NO: 26-4012 | PERIOD: FROM 9/ 1/2009 TO 12/31/2009 | PREPARED 5/28/2010 | WORKSHEET B PART I

	COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION 0	NEW CAP REL COSTS-BLDG & 3	NEW CAP REL COSTS-BLDG & 3.01	NEW CAP REL COSTS-MVBLE E 4	EMPLOYEE BENEFITS 5	SUBTOTAL 5a.00	ADMINISTRATIVE & GENERAL 6
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &	362,579	362,579					
003 01	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E	202,869			202,869			
005	EMPLOYEE BENEFITS	1,172,053	4,415		2,470	1,178,938		
006	ADMINISTRATIVE & GENERAL	1,676,075	31,714		17,745	229,129	1,954,663	1,954,663
007	MAINTENANCE & REPAIRS	176,913	8,101		4,533	16,739	206,286	67,699
009	LAUNDRY & LINEN SERVICE	27,344	3,573		1,999		32,916	10,802
010	HOUSEKEEPING	86,561	1,488		833		88,882	29,169
011	DIETARY	295,605	7,724		4,322	24,380	332,031	108,966
012	CAFETERIA		10,839		6,065		16,904	5,548
014	NURSING ADMINISTRATION	243,906	1,262		706	62,980	308,854	101,359
016	PHARMACY							
017	MEDICAL RECORDS & LIBRARY	128,068	6,732		3,767	22,144	160,711	52,742
018	SOCIAL SERVICE	147,732	7,938		4,441	41,139	201,250	66,046
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	1,831,768	148,388		83,023	459,167	2,522,346	827,778
030	CHEMICAL DEPENDENCY UNIT	179,443	19,688		11,016	46,462	256,609	84,214
	ANCILLARY SRVC COST CNTRS							
041	RADIOLOGY-DIAGNOSTIC							
044	LABORATORY							
054	ELECTROENCEPHALOGRAPHY	34,356					34,356	11,275
056	DRUGS CHARGED TO PATIENTS	137,154	1,670		935	916	140,675	46,167
	OUTPAT SERVICE COST CNTRS							
060	CLINIC	1,169,538	109,047		61,014	273,763	1,613,362	529,472
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	7,871,964	362,579		202,869	1,176,819	7,869,845	1,941,237
	NONREIMBURS COST CENTERS							
097	RESEARCH							
100	OTHER NONREIMBURSABLE COS	38,791				2,119	40,910	13,426
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	7,910,755	362,579		202,869	1,178,938	7,910,755	1,954,663

	COST CENTER DESCRIPTION	MAINTENANCE & REPAIRS	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	PHARMACY
		7	9	10	11	12	14	16
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
003 01	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL							
007	MAINTENANCE & REPAIRS	273,985						
009	LAUNDRY & LINEN SERVICE	3,075	46,793					
010	HOUSEKEEPING	1,281		119,332				
011	DIETARY	6,648		2,942	450,587			
012	CAFETERIA	9,329		4,129	49,948	85,858		
014	NURSING ADMINISTRATION	1,086		481		5,119	416,899	
016	PHARMACY							
017	MEDICAL RECORDS & LIBRARY	5,794		2,564		3,483		
018	SOCIAL SERVICE	6,832		3,024		4,486		
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	127,707	40,929	56,521	321,128	56,463	364,656	
030	CHEMICAL DEPENDENCY UNIT	16,944	5,864	7,499	45,954	5,541	52,243	
	ANCILLARY SRVC COST CNTRS							
041	RADIOLOGY-DIAGNOSTIC							
044	LABORATORY							
054	ELECTROENCEPHALOGRAPHY							
056	DRUGS CHARGED TO PATIENTS	1,438		636		264		
	OUTPAT SERVICE COST CNTRS							
060	CLINIC	93,851		41,536	33,557	10,449		
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	273,985	46,793	119,332	450,587	85,805	416,899	
	NONREIMBURS COST CENTERS							
097	RESEARCH					53		
100	OTHER NONREIMBURSABLE COS							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	273,985	46,793	119,332	450,587	85,858	416,899	

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
		17	18	25	26	27
	GENERAL SERVICE COST CNTR					
003	NEW CAP REL COSTS-BLDG &					
003 01	NEW CAP REL COSTS-BLDG &					
004	NEW CAP REL COSTS-MVBLE E					
005	EMPLOYEE BENEFITS					
006	ADMINISTRATIVE & GENERAL					
007	MAINTENANCE & REPAIRS					
009	LAUNDRY & LINEN SERVICE					
010	HOUSEKEEPING					
011	DIETARY					
012	CAFETERIA					
014	NURSING ADMINISTRATION					
016	PHARMACY					
017	MEDICAL RECORDS & LIBRARY	225,294				
018	SOCIAL SERVICE		281,638			
	INPAT ROUTINE SRVC CNTRS					
025	ADULTS & PEDIATRICS	155,973	249,274	4,722,775		4,722,775
030	CHEMICAL DEPENDENCY UNIT	17,330	32,364	524,562		524,562
	ANCILLARY SRVC COST CNTRS					
041	RADIOLOGY-DIAGNOSTIC					
044	LABORATORY					
054	ELECTROENCEPHALOGRAPHY			45,631		45,631
056	DRUGS CHARGED TO PATIENTS			189,180		189,180
	OUTPAT SERVICE COST CNTRS					
060	CLINIC	51,991		2,374,218		2,374,218
	SPEC PURPOSE COST CENTERS					
095	SUBTOTALS	225,294	281,638	7,856,366		7,856,366
	NONREIMBURS COST CENTERS					
097	RESEARCH			53		53
100	OTHER NONREIMBURSABLE COS			54,336		54,336
101	CROSS FOOT ADJUSTMENT					
102	NEGATIVE COST CENTER					
103	TOTAL	225,294	281,638	7,910,755		7,910,755

ALLOCATION OF NEW CAPITAL RELATED COSTS

PROVIDER NO: 26-4012

PERIOD: FROM 9/ 1/2009 TO 12/31/2009

PREPARED 5/28/2010
WORKSHEET B
PART III

	COST CENTER DESCRIPTION	DIR ASSGNED NEW CAPITAL REL COSTS	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL
		0	3	3.01	4	4a	5	6
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
003 01	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS		4,415		2,470	6,885	6,885	
006	ADMINISTRATIVE & GENERAL		31,714		17,745	49,459	1,337	50,796
007	MAINTENANCE & REPAIRS		8,101		4,533	12,634	98	1,759
009	LAUNDRY & LINEN SERVICE		3,573		1,999	5,572		281
010	HOUSEKEEPING		1,488		833	2,321		758
011	DIETARY		7,724		4,322	12,046	142	2,832
012	CAFETERIA		10,839		6,065	16,904		144
014	NURSING ADMINISTRATION		1,262		706	1,968	367	2,634
016	PHARMACY							
017	MEDICAL RECORDS & LIBRARY		6,732		3,767	10,499	129	1,371
018	SOCIAL SERVICE		7,938		4,441	12,379	240	1,716
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS		148,388		83,023	231,411	2,687	21,512
030	CHEMICAL DEPENDENCY UNIT		19,688		11,016	30,704	271	2,188
	ANCILLARY SRVC COST CNTRS							
041	RADIOLOGY-DIAGNOSTIC							
044	LABORATORY							
054	ELECTROENCEPHALOGRAPHY							293
056	DRUGS CHARGED TO PATIENTS		1,670		935	2,605	5	1,200
	OUTPAT SERVICE COST CNTRS							
060	CLINIC		109,047		61,014	170,061	1,597	13,759
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS		362,579		202,869	565,448	6,873	50,447
	NONREIMBURS COST CENTERS							
097	RESEARCH							
100	OTHER NONREIMBURSABLE COS						12	349
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL		362,579		202,869	565,448	6,885	50,796

ALLOCATION OF NEW CAPITAL RELATED COSTS

PROVIDER NO: 26-4012 | PERIOD: FROM 9/ 1/2009 TO 12/31/2009 | PREPARED 5/28/2010 | WORKSHEET B PART III

	COST CENTER DESCRIPTION	MAINTENANCE & REPAIRS	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	PHARMACY
		7	9	10	11	12	14	16
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
003 01	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL							
007	MAINTENANCE & REPAIRS	14,491						
009	LAUNDRY & LINEN SERVICE	163	6,016					
010	HOUSEKEEPING	68		3,147				
011	DIETARY	352		78	15,450			
012	CAFETERIA	493		109	1,713	19,363		
014	NURSING ADMINISTRATION	57		13		1,154	6,193	
016	PHARMACY							
017	MEDICAL RECORDS & LIBRARY	306		68		785		
018	SOCIAL SERVICE	361		80		1,012		
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	6,755	5,262	1,489	11,010	12,734	5,417	
030	CHEMICAL DEPENDENCY UNIT	896	754	198	1,576	1,250	776	
	ANCILLARY SRVC COST CNTRS							
041	RADIOLOGY-DIAGNOSTIC							
044	LABORATORY							
054	ELECTROENCEPHALOGRAPHY							
056	DRUGS CHARGED TO PATIENTS	76		17		60		
	OUTPAT SERVICE COST CNTRS							
060	CLINIC	4,964		1,095	1,151	2,356		
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	14,491	6,016	3,147	15,450	19,351	6,193	
	NONREIMBURS COST CENTERS							
097	RESEARCH					12		
100	OTHER NONREIMBURSABLE COS							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	14,491	6,016	3,147	15,450	19,363	6,193	

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		17	18	25	26	27
	GENERAL SERVICE COST CNTR					
003	NEW CAP REL COSTS-BLDG &					
003 01	NEW CAP REL COSTS-BLDG &					
004	NEW CAP REL COSTS-MVBLE E					
005	EMPLOYEE BENEFITS					
006	ADMINISTRATIVE & GENERAL					
007	MAINTENANCE & REPAIRS					
009	LAUNDRY & LINEN SERVICE					
010	HOUSEKEEPING					
011	DIETARY					
012	CAFETERIA					
014	NURSING ADMINISTRATION					
016	PHARMACY					
017	MEDICAL RECORDS & LIBRARY	13,158				
018	SOCIAL SERVICE		15,788			
	INPAT ROUTINE SRVC CNTRS					
025	ADULTS & PEDIATRICS	9,110	13,974	321,361		321,361
030	CHEMICAL DEPENDENCY UNIT	1,012	1,814	41,439		41,439
	ANCILLARY SRVC COST CNTRS					
041	RADIOLOGY-DIAGNOSTIC					
044	LABORATORY					
054	ELECTROENCEPHALOGRAPHY			293		293
056	DRUGS CHARGED TO PATIENTS			3,963		3,963
	OUTPAT SERVICE COST CNTRS					
060	CLINIC	3,036		198,019		198,019
	SPEC PURPOSE COST CENTERS					
095	SUBTOTALS	13,158	15,788	565,075		565,075
	NONREIMBURS COST CENTERS					
097	RESEARCH			12		12
100	OTHER NONREIMBURSABLE COS			361		361
101	CROSS FOOT ADJUSTMENTS					
102	NEGATIVE COST CENTER					
103	TOTAL	13,158	15,788	565,448		565,448

	COST CENTER DESCRIPTION	NEW CAP REL COSTS-BLDG & EQUIP (SQUARE FEET)	NEW CAP REL COSTS-BLDG & EQUIP (SQUARE FEET)	NEW CAP REL COSTS-MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)
		3	3.01	4	5	6a.00	6
	GENERAL SERVICE COST						
003	NEW CAP REL COSTS-BLD	57,735					
003 01	NEW CAP REL COSTS-BLD		57,735				
004	NEW CAP REL COSTS-MVB			57,735			
005	EMPLOYEE BENEFITS	703	703	703	12,668,461		
006	ADMINISTRATIVE & GENE	5,050	5,050	5,050	2,462,136	-1,954,663	5,956,092
007	MAINTENANCE & REPAIRS	1,290	1,290	1,290	179,872		206,286
009	LAUNDRY & LINEN SERVI	569	569	569			32,916
010	HOUSEKEEPING	237	237	237			88,882
011	DIETARY	1,230	1,230	1,230	261,974		332,031
012	CAFETERIA	1,726	1,726	1,726			16,904
014	NURSING ADMINISTRATIO	201	201	201	676,765		308,854
016	PHARMACY						
017	MEDICAL RECORDS & LIB	1,072	1,072	1,072	237,948		160,711
018	SOCIAL SERVICE	1,264	1,264	1,264	442,069		201,250
	INPAT ROUTINE SRVC CN						
025	ADULTS & PEDIATRICS	23,628	23,628	23,628	4,934,061		2,522,346
030	CHEMICAL DEPENDENCY U	3,135	3,135	3,135	499,263		256,609
	ANCILLARY SRVC COST C						
041	RADIOLOGY-DIAGNOSTIC						
044	LABORATORY						34,356
054	ELECTROENCEPHALOGRAPH						140,675
056	DRUGS CHARGED TO PATI	266	266	266	9,842		
	OUTPAT SERVICE COST C						
060	CLINIC	17,364	17,364	17,364	2,941,756		1,613,362
	SPEC PURPOSE COST CEN						
095	SUBTOTALS	57,735	57,735	57,735	12,645,686	-1,954,663	5,915,182
	NONREIMBURS COST CENT						
097	RESEARCH						
100	OTHER NONREIMBURSABLE				22,775		40,910
101	CROSS FOOT ADJUSTMENT						
102	NEGATIVE COST CENTER						
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	362,579		202,869	1,178,938		1,954,663
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	6.280055		3.513796	.093061		.328179
105	COST TO BE ALLOCATED (WRKSHT B, PART II)						
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)						
107	COST TO BE ALLOCATED (WRKSHT B, PART III				6,885		50,796
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)				.000543		.008528

	COST CENTER DESCRIPTION	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LIN EN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS ERVED)	CAFETERIA S(PAID FTE'S)	NURSING ADMIN ISTRATION (PATIENT DAYS)	PHARMACY (PERCENT)
		7	9	10	11	12	14	16
	GENERAL SERVICE COST							
003	NEW CAP REL COSTS-BLD							
003 01	NEW CAP REL COSTS-BLD							
004	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE							
007	MAINTENANCE & REPAIRS	50,692						
009	LAUNDRY & LINEN SERVI	569	9,161					
010	HOUSEKEEPING	237		49,886				
011	DIETARY	1,230		1,230	33,730			
012	CAFETERIA	1,726		1,726	3,739	1,627		
014	NURSING ADMINISTRATIO	201		201		97	9,161	
016	PHARMACY							100
017	MEDICAL RECORDS & LIB	1,072		1,072		66		
018	SOCIAL SERVICE	1,264		1,264		85		
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	23,628	8,013	23,628	24,039	1,070	8,013	
030	CHEMICAL DEPENDENCY U	3,135	1,148	3,135	3,440	105	1,148	
	ANCILLARY SRVC COST C							
041	RADIOLOGY-DIAGNOSTIC							
044	LABORATORY							
054	ELECTROENCEPHALOGRAPH							
056	DRUGS CHARGED TO PATI	266		266		5		100
	OUTPAT SERVICE COST C							
060	CLINIC	17,364		17,364	2,512	198		
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	50,692	9,161	49,886	33,730	1,626	9,161	100
	NONREIMBURS COST CENT							
097	RESEARCH					1		
100	OTHER NONREIMBURSABLE							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	273,985	46,793	119,332	450,587	85,858	416,899	
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	5.404896	5.107848	2.392094	13.358642	52.770744	45.508023	
105	COST TO BE ALLOCATED (WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)							
107	COST TO BE ALLOCATED (WRKSHT B, PART III	14,491	6,016	3,147	15,450	19,363	6,193	
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	.285864	.656697	.063084	.458049	11.901045	.676018	

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)
		17	18
	GENERAL SERVICE COST		
003	NEW CAP REL COSTS-BLD		
003 01	NEW CAP REL COSTS-BLD		
004	NEW CAP REL COSTS-MVB		
005	EMPLOYEE BENEFITS		
006	ADMINISTRATIVE & GENE		
007	MAINTENANCE & REPAIRS		
009	LAUNDRY & LINEN SERVI		
010	HOUSEKEEPING		
011	DIETARY		
012	CAFETERIA		
014	NURSING ADMINISTRATIO		
016	PHARMACY		
017	MEDICAL RECORDS & LIB	65	
018	SOCIAL SERVICE		6,048
	INPAT ROUTINE SRVC CN		
025	ADULTS & PEDIATRICS	45	5,353
030	CHEMICAL DEPENDENCY U	5	695
	ANCILLARY SRVC COST C		
041	RADIOLOGY-DIAGNOSTIC		
044	LABORATORY		
054	ELECTROENCEPHALOGRAPH		
056	DRUGS CHARGED TO PATI		
	OUTPAT SERVICE COST C		
060	CLINIC	15	
	SPEC PURPOSE COST CEN		
095	SUBTOTALS	65	6,048
	NONREIMBURS COST CENT		
097	RESEARCH		
100	OTHER NONREIMBURSABLE		
101	CROSS FOOT ADJUSTMENT		
102	NEGATIVE COST CENTER		
103	COST TO BE ALLOCATED (PER WRKSHT B, PART	225,294	281,638
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	3,466.061538	46.567130
105	COST TO BE ALLOCATED (PER WRKSHT B, PART		
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)		
107	COST TO BE ALLOCATED (PER WRKSHT B, PART	13,158	15,788
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	202.430769	2.610450

COMPUTATION OF RATIO OF COSTS TO CHARGES

PROVIDER NO: 26-4012

PERIOD: FROM 9/ 1/2009 TO 12/31/2009

PREPARED 5/28/2010

WORKSHEET C PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	4,722,775		4,722,775		4,722,775
30	CHEMICAL DEPENDENCY UNIT	524,562		524,562		524,562
	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY					
54	ELECTROENCEPHALOGRAPHY	45,631		45,631		45,631
56	DRUGS CHARGED TO PATIENTS	189,180		189,180		189,180
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	2,374,218		2,374,218		2,374,218
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	7,856,366		7,856,366		7,856,366
102	LESS OBSERVATION BEDS					
103	TOTAL	7,856,366		7,856,366		7,856,366

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 INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	7,121,530		7,121,530			
30	CHEMICAL DEPENDENCY UNIT	574,000		574,000			
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
54	ELECTROENCEPHALOGRAPHY	39,809		39,809	1.146248	1.146248	1.146248
56	DRUGS CHARGED TO PATIENTS	418,183		418,183	.452386	.452386	.452386
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		9,058,656	9,058,656	.262094	.262094	.262094
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	8,153,522	9,058,656	17,212,178			
102	LESS OBSERVATION BEDS						
103	TOTAL	8,153,522	9,058,656	17,212,178			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III,COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
54	ELECTROENCEPHALOGRAPHY	45,631	293	45,338			45,631
56	DRUGS CHARGED TO PATIENTS	189,180	3,963	185,217			189,180
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	2,374,218	198,019	2,176,199			2,374,218
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	2,609,029	202,275	2,406,754			2,609,029
102	LESS OBSERVATION BEDS						
103	TOTAL	2,609,029	202,275	2,406,754			2,609,029

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC			
44	LABORATORY			
54	ELECTROENCEPHALOGRAPHY	39,809	1.146248	1.146248
56	DRUGS CHARGED TO PATIENTS	418,183	.452386	.452386
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	9,058,656	.262094	.262094
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	9,516,648		
102	LESS OBSERVATION BEDS			
103	TOTAL	9,516,648		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

TITLE XVIII, PART A

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL CAPITAL REL COST (B, II) 1	OLD CAPITAL SWING BED ADJUSTMENT 2	OLD CAPITAL REDUCED CAP RELATED COST 3	NEW CAPITAL CAPITAL REL COST (B,III) 4	NEW CAPITAL SWING BED ADJUSTMENT 5	NEW CAPITAL REDUCED CAP RELATED COST 6
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS				321,361		321,361
30	CHEMICAL DEPENDENCY UNIT				41,439		41,439
101	TOTAL				362,800		362,800

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

TITLE XVIII, PART A

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	INPAT PROGRAM OLD CAP CST 10	NEW CAPITAL PER DIEM 11	INPAT PROGRAM NEW CAP CST 12
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	8,013	1,973			40.10	79,117
30	CHEMICAL DEPENDENCY UNIT	1,148				36.10	
101	TOTAL	9,161	1,973				79,117

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

PROVIDER NO: 26-4012 | PERIOD: FROM 9/ 1/2009 TO 12/31/2009 | PREPARED 5/28/2010

COMPONENT NO: 26-4012 | WORKSHEET D PART II

TITLE XVIII, PART A HOSPITAL PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	OLD CAPITAL CST/CHRG RATIO 5	COSTS 6
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY		293	39,809	38,660		
54	ELECTROENCEPHALOGRAPHY		3,963	418,183	201,659		
56	DRUGS CHARGED TO PATIENTS						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		198,019	9,058,656			
	OTHER REIMBURS COST CNTRS						
101	TOTAL		202,275	9,516,648	240,319		

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

TITLE XVIII, PART A HOSPITAL

WKST A LINE NO.	COST CENTER DESCRIPTION	NEW CAPITAL CST/CHRG RATIO 7	COSTS 8
	ANCILLARY SRVC COST CNTRS		
41	RADIOLOGY-DIAGNOSTIC		
44	LABORATORY		
54	ELECTROENCEPHALOGRAPHY	.007360	285
56	DRUGS CHARGED TO PATIENTS	.009477	1,911
	OUTPAT SERVICE COST CNTRS		
60	CLINIC	.021860	
	OTHER REIMBURS COST CNTRS		
101	TOTAL		2,196

PROVIDER NO: 26-4012 PERIOD: FROM 9/ 1/2009 TO 12/31/2009 PREPARED 5/28/2010

PPS

WORKSHEET D
PART III

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

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	MED EDUCATN COST 2	SWING BED ADJ AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS					8,013	
30	CHEMICAL DEPENDENCY UNIT					1,148	
101	TOTAL					9,161	

PROVIDER NO: 26-4012 | PERIOD: FROM 9/ 1/2009 TO 12/31/2009 | PREPARED 5/28/2010 | WORKSHEET D PART III

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

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT PROG DAYS 7	INPAT PROGRAM PASS THRU COST 8
25	ADULTS & PEDIATRICS	1,973	
30	CHEMICAL DEPENDENCY UNIT		
101	TOTAL	1,973	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

I PROVIDER NO: 26-4012 I COMPONENT NO: 26-4012
I PERIOD: I FROM 9/ 1/2009 I TO 12/31/2009
I PREPARED 5/28/2010 I WORKSHEET D I PART IV

TITLE XVIII, PART A HOSPITAL PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	1.01	MED ED NRS SCHOOL COST 2	MED ED ALLIED HEALTH COST 2.01	MED ED ALL OTHER COSTS 2.02	BLOOD CLOT FOR HEMOPHILIACS 2.03
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
54	ELECTROENCEPHALOGRAPHY						
56	DRUGS CHARGED TO PATIENTS						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS							
41	RADIOLOGY-DIAGNOSTIC							
44	LABORATORY			39,809			38,660	
54	ELECTROENCEPHALOGRAPHY			418,183			201,659	
56	DRUGS CHARGED TO PATIENTS							
	OUTPAT SERVICE COST CNTRS							
60	CLINIC			9,058,656				
	OTHER REIMBURS COST CNTRS							
101	TOTAL			9,516,648			240,319	

TITLE XVIII, PART A HOSPITAL PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OUTPAT PROG CHARGES 8	OUTPAT PROG D,V COL 5.03 8.01	OUTPAT PROG D,V COL 5.04 8.02	OUTPAT PROG PASS THRU COST 9	COL 8.01 * COL 5 9.01	COL 8.02 * COL 5 9.02
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
54	ELECTROENCEPHALOGRAPHY						
56	DRUGS CHARGED TO PATIENTS						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	5,596,175					
	OTHER REIMBURS COST CNTRS						
101	TOTAL	5,596,175					

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 26-4012 I COMPONENT NO: 26-4012 I PERIOD: I FROM 9/ 1/2009 I TO 12/31/2009 I I PREPARED 5/28/2010 I WORKSHEET D I PART V I

TITLE XVIII, PART B HOSPITAL

	Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic
		1	1.02	2	3	4
(A)	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY	1.146248	1.146248			
54	ELECTROENCEPHALOGRAPHY	.452386	.452386			
56	DRUGS CHARGED TO PATIENTS					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	.262094	.262094			
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: 26-4012 I COMPONENT NO: 26-4012 I PERIOD: I FROM 9/ 1/2009 I TO 12/31/2009 I PREPARED 5/28/2010 I WORKSHEET D I PART V

TITLE XVIII, PART B HOSPITAL

	Cost Center Description	All Other (1)	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr
		5	5.01	5.02	5.03	6
(A)	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY					
54	ELECTROENCEPHALOGRAPHY					
56	DRUGS CHARGED TO PATIENTS					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC		5,596,175			
101	SUBTOTAL		5,596,175			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES		5,596,175			

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

PROVIDER NO: 26-4012 | PERIOD: FROM 9/ 1/2009 TO 12/31/2009 | PREPARED 5/28/2010
COMPONENT NO: 26-4012 | WORKSHEET D PART V

TITLE XVIII, PART B HOSPITAL

	Cost Center Description	Outpatient Radiology	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services
		7	8	9	9.01	9.02
(A)	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY					
54	ELECTROENCEPHALOGRAPHY					
56	DRUGS CHARGED TO PATIENTS					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC				1,466,724	
101	SUBTOTAL				1,466,724	
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES				1,466,724	

(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

TITLE XVIII, PART B HOSPITAL

	Cost Center Description	PPS Services 1/1 to FYE	Hospital I/P Part B Charges	Hospital I/P Part B Costs
		9.03	10	11
(A)	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC			
44	LABORATORY			
54	ELECTROENCEPHALOGRAPHY			
56	DRUGS CHARGED TO PATIENTS			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
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)

TITLE XVIII PART A HOSPITAL PPS

PART I - ALL PROVIDER COMPONENTS 1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	8,013
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	8,013
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	8,013
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	
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)	1,973
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	4,722,775
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	4,722,775

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	7,121,530
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	7,121,530
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	.663169
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	888.75
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	
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	4,722,775

TITLE XVIII PART A HOSPITAL PPS

PART II - HOSPITAL AND SUBPROVIDERS ONLY 1

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	589.39
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,162,866
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,162,866

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT					
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	CHEMICAL DEPENDENCY UNIT	524,562	1,148	456.94		1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST					135,542
49	TOTAL PROGRAM INPATIENT COSTS					1,298,408

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	79,117
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	2,196
52	TOTAL PROGRAM EXCLUDABLE COST	81,313
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	1,217,095

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

TITLE XVIII PART A HOSPITAL PPS

PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY 1

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	589.39
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		4,722,775			
87	NEW CAPITAL-RELATED COST	321,361	4,722,775	.068045		
88	NON PHYSICIAN ANESTHETIST		4,722,775			
89	MEDICAL EDUCATION		4,722,775			
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	8,013
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	8,013
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	8,013
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,661
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	4,722,775
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	4,722,775
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	7,121,530
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	7,121,530
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.663169
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	888.75
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	4,722,775

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	589.39
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	978,977
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	978,977

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT					
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	CHEMICAL DEPENDENCY UNIT	524,562	1,148	456.94		
48	PROGRAM INPATIENT ANCILLARY SERVICE COST					1
49	TOTAL PROGRAM INPATIENT COSTS					31,865
						1,010,842

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

TITLE XIX - I/P HOSPITAL OTHER

PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY 1

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	589.39
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: 26-4012 I PERIOD: I FROM 9/ 1/2009 I TO 12/31/2009 I PREPARED 5/28/2010 I WORKSHEET D-4
I COMPONENT NO: 26-4012 I

TITLE XVIII, PART A HOSPITAL PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		1,746,807	
30	CHEMICAL DEPENDENCY UNIT			
	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC			
44	LABORATORY	1.146248	38,660	44,314
54	ELECTROENCEPHALOGRAPHY	.452386	201,659	91,228
56	DRUGS CHARGED TO PATIENTS			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.262094		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		240,319	135,542
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		240,319	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 26-4012 I COMPONENT NO: 26-4012 I PERIOD: I FROM 9/ 1/2009 I TO 12/31/2009 I PREPARED 5/28/2010 I WORKSHEET D-4

TITLE XIX HOSPITAL OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		1,453,375	
30	CHEMICAL DEPENDENCY UNIT			
	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC			
44	LABORATORY	1.146248		
54	ELECTROENCEPHALOGRAPHY	.452386	70,437	31,865
56	DRUGS CHARGED TO PATIENTS			
	OUTPAT SERVICE COST CNTRS	.262094		
60	CLINIC			
	OTHER REIMBURS COST CNTRS		70,437	31,865
101	TOTAL			
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES		70,437	
103	NET CHARGES			

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL
1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	1,466,724
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	1,614,735
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9,02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	1,614,735
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	326,730
18.01	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 17.01 (SEE INSTRUCTIONS)	1,288,005
19	SUBTOTAL (SEE INSTRUCTIONS)	
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	1,288,005
23	SUBTOTAL	3,328
24	PRIMARY PAYER PAYMENTS	1,284,677
25	SUBTOTAL	
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	73,619
27	BAD DEBTS (SEE INSTRUCTIONS)	51,533
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	1,336,210
28	SUBTOTAL	
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	1,336,210
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	1,305,470
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	30,740
35	BALANCE DUE PROVIDER/PROGRAM	
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	
	TO BE COMPLETED BY CONTRACTOR	
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)	
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)	
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY	
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	
54	TOTAL (SUM OF LINES 51 AND 53)	

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

PROVIDER NO:	PERIOD:	PREPARED 5/28/2010
26-4012	FROM 9/ 1/2009	WORKSHEET E-1
COMPONENT NO:	TO 12/31/2009	
26-4012		

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

TITLE XVIII HOSPITAL

DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	AMOUNT 2	PART B MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER			1,115,158		1,284,670
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
ADJUSTMENTS TO PROVIDER	.01		4,800		20,800
ADJUSTMENTS TO PROVIDER	.02				
ADJUSTMENTS TO PROVIDER	.03				
ADJUSTMENTS TO PROVIDER	.04				
ADJUSTMENTS TO PROVIDER	.05				
ADJUSTMENTS TO PROGRAM	.50				
ADJUSTMENTS TO PROGRAM	.51				
ADJUSTMENTS TO PROGRAM	.52				
ADJUSTMENTS TO PROGRAM	.53				
ADJUSTMENTS TO PROGRAM	.54				
SUBTOTAL	.99		4,800		20,800
4 TOTAL INTERIM PAYMENTS			1,119,958		1,305,470
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
TENTATIVE TO PROVIDER	.01				
TENTATIVE TO PROVIDER	.02				
TENTATIVE TO PROVIDER	.03				
TENTATIVE TO PROGRAM	.50				
TENTATIVE TO PROGRAM	.51				
TENTATIVE TO PROGRAM	.52				
SUBTOTAL	.99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01		12,938		30,740
	SETTLEMENT TO PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY			1,132,896		1,336,210

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

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

1	INPATIENT HOSPITAL SERVICES (SEE INSTRUCTIONS)	
1.01	HOSPITAL SPECIFIC AMOUNT (SEE INSTRUCTIONS)	
1.02	ENTER FROM THE PS&R, THE IRF PPS PAYMENT	
1.03	MEDICARE SSI RATIO (IRF PPS ONLY) (SEE INSTR.)	
1.04	INPATIENT REHABILITATION FACILITY LIP PAYMENTS (SEE INSTRUCTIONS)	
1.05	OUTLIER PAYMENTS	
1.06	TOTAL PPS PAYMENTS (SUM OF LINES 1.01, (1.02, 1.04 FOR COLUMNS 1 & 1.01), 1.05 AND 1.42)	
1.07	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUNCTIONS)	
	INPATIENT PSYCHIATRIC FACILITY (IPF)	
1.08	NET FEDERAL IPF PPS PAYMENTS (EXCLUDING OUTLIER, ECT, STOP-LOSS, AND MEDICAL EDUCATION PAYMENTS)	1,259,909
1.09	NET IPF PPS OUTLIER PAYMENTS	146
1.10	NET IPF PPS ECT PAYMENTS	7,005
1.11	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR LATEST COST REPORT FILED PRIOR TO NOVEMBER 15, 2004 (SEE INSTRUCTIONS)	
1.12	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)	
1.13	CURRENT YEARS UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.14	CURRENT YEARS UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.15	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.16	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	65.680328
1.17	MEDICAL EDUCATION ADJUSTMENT FACTOR {((1 + (LINE 1.15/1.16)) RAISED TO THE POWER OF .5150 - 1}.	
1.18	MEDICAL EDUCATION ADJUSTMENT (LINE 1.08 MULTIPLIED BY LINE 1.17).	
1.19	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1.08, 1.09, 1.10 AND 1.18)	1,267,060
1.20	STOP LOSS PAYMENT FLOOR (LINE 1 x 70%)	
1.21	ADJUSTED NET PAYMENT FLOOR (LINE 1.20 x THE APPROPRIATE FEDERAL BLEND PERCENTAGE)	
1.22	STOP LOSS ADJUSTMENT (IF LINE 1.21 IS GREATER THAN LINE 1.19 ENTER THE AMOUNT ON LINE 1.21 LESS LINE 1.19 OTHERWISE ENTER -0-)	
1.23	TOTAL IPF PPS PAYMENTS (SUM OF LINES 1.01, 1.19 AND 1.22)	1,267,060
	INPATIENT REHABILITATION FACILITY (IRF)	
1.35	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR COST REPORT PERIODS ENDING ON/OR PRIOR TO NOVEMBER 15, 2004. (SEE INST.)	
1.36	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)	
1.37	CURRENT YEAR'S UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.38	CURRENT YEAR'S UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.39	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.40	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	
1.41	MEDICAL EDUCATION ADJUSTMENT FACTOR {((1 + (LINE 1.39/1.40)) RAISED TO THE POWER OF .9012 - 1}.	
1.42	MEDICAL EDUCATION ADJUSTMENT (LINE 1.02 MULTIPLIED BY LINE 1.41).	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	1,267,060
4	SUBTOTAL (SEE INSTRUCTIONS)	3,735
5	PRIMARY PAYER PAYMENTS	1,263,325
6	SUBTOTAL	101,460
7	DEDUCTIBLES	1,161,865
8	SUBTOTAL	46,725
9	COINSURANCE	1,115,140
10	SUBTOTAL	25,365
11	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROF SERVS)	17,756
11.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
11.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
12	SUBTOTAL	1,132,896
13	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	

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

13.01	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)	
14	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
15	OTHER ADJUSTMENTS (SPECIFY)	
15.99	OUTLIER RECONCILIATION ADJUSTMENT	
16	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
17	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	1,132,896
18	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	1,119,958
19	INTERIM PAYMENTS	
19.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	12,938
20	BALANCE DUE PROVIDER/PROGRAM	
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

----- FI ONLY ----------

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

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

	TITLE XIX	HOSPITAL	OTHER TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
	COMPUTATION OF NET COST OF COVERED SERVICE			
1	INPATIENT HOSPITAL/SNF/NF SERVICES		1,010,842	
2	MEDICAL AND OTHER SERVICES			
3	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			
4	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)			
5	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		1,010,842	
6	SUBTOTAL		575,184	
7	INPATIENT PRIMARY PAYER PAYMENTS			
8	OUTPATIENT PRIMARY PAYER PAYMENTS		435,658	
9	SUBTOTAL			
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES		1,453,375	
10	ROUTINE SERVICE CHARGES		70,437	
11	ANCILLARY SERVICE CHARGES			
12	INTERNS AND RESIDENTS SERVICE CHARGES			
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE			
14	TEACHING PHYSICIANS			
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION		1,523,812	
16	TOTAL REASONABLE CHARGES			
	CUSTOMARY CHARGES			
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			
19	RATIO OF LINE 17 TO LINE 18			
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		1,523,812	
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		1,088,154	
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
23	COST OF COVERED SERVICES		435,658	
	PROSPECTIVE PAYMENT AMOUNT			
24	OTHER THAN OUTLIER PAYMENTS			
25	OUTLIER PAYMENTS			
26	PROGRAM CAPITAL PAYMENTS			
27	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS			
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS			
30	SUBTOTAL		435,658	
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)			
32	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE XVIII ENTER AMOUNT FROM LINE 30		435,658	
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34	EXCESS OF REASONABLE COST			
35	SUBTOTAL		435,658	
36	COINSURANCE			
37	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19			
38	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			
38.01	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING BEFORE 10/01/05 (SEE INSTRUCTIONS)			
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)			
39	UTILIZATION REVIEW			
40	SUBTOTAL (SEE INSTRUCTIONS)		435,658	
41	INPATIENT ROUTINE SERVICE COST			
42	MEDICARE INPATIENT ROUTINE CHARGES			
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT OF PART A SERVICES			
45	RATIO OF LINE 43 TO 44			
46	TOTAL CUSTOMARY CHARGES			
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			
50	OTHER ADJUSTMENTS (SPECIFY)			
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			
52	SUBTOTAL		435,658	
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			

CALCULATION OF REIMBURSEMENT SETTLEMENT

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

PROVIDER NO:	PERIOD:	PREPARED 5/28/2010
26-4012	FROM 9/ 1/2009	WORKSHEET E-3
COMPONENT NO:	TO 12/31/2009	PART III
-		

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

	TITLE XIX	HOSPITAL	OTHER TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER		435,658	
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
57	INTERIM PAYMENTS			
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			
58	BALANCE DUE PROVIDER/PROGRAM		435,658	
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.			

BALANCE SHEET

PROVIDER NO: 26-4012 | PERIOD: FROM 9/ 1/2009 TO 12/31/2009 | PREPARED 5/28/2010

WORKSHEET G

	ASSETS	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
	CURRENT ASSETS				
1	CASH ON HAND AND IN BANKS	496,939			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	8,681,704			
5	OTHER RECEIVABLES				
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-3,108,898			
7	INVENTORY	107,391			
8	PREPAID EXPENSES	103,209			
9	OTHER CURRENT ASSETS	32,193			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	6,312,538			
	FIXED ASSETS				
12	LAND				
12.01					
13	LAND IMPROVEMENTS				
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS				
14.01	LESS ACCUMULATED DEPRECIATION				
15	LEASEHOLD IMPROVEMENTS	517,103			
15.01	LESS ACCUMULATED DEPRECIATION	-127,411			
16	FIXED EQUIPMENT	1,911,115			
16.01	LESS ACCUMULATED DEPRECIATION	-1,019,620			
17	AUTOMOBILES AND TRUCKS	392,516			
17.01	LESS ACCUMULATED DEPRECIATION	-265,075			
18	MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	1,408,628			
	OTHER ASSETS				
22	INVESTMENTS	200,000			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	33,879			
26	TOTAL OTHER ASSETS	233,879			
27	TOTAL ASSETS	7,955,045			

	LIABILITIES AND FUND BALANCE	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
	CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE	542,156			
29	SALARIES, WAGES & FEES PAYABLE	500,282			
30	PAYROLL TAXES PAYABLE	24,765			
31	NOTES AND LOANS PAYABLE (SHORT TERM)				
32	DEFERRED INCOME				
33	ACCELERATED PAYMENTS				
34	DUE TO OTHER FUNDS				
35	OTHER CURRENT LIABILITIES	597,357			
36	TOTAL CURRENT LIABILITIES	1,664,560			
	LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE				
38	NOTES PAYABLE				
39	UNSECURED LOANS				
40.01	LOANS PRIOR TO 7/1/66				
40.02	ON OR AFTER 7/1/66				
41	OTHER LONG TERM LIABILITIES				
42	TOTAL LONG-TERM LIABILITIES				
43	TOTAL LIABILITIES	1,664,560			
	CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE	6,290,485			
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	6,290,485			
52	TOTAL LIABILITIES AND FUND BALANCES	7,955,045			

STATEMENT OF CHANGES IN FUND BALANCES

		GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4
1	FUND BALANCE AT BEGINNING OF PERIOD		6,124,702		
2	NET INCOME (LOSS)		890,786		
3	TOTAL		7,015,488		
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	ADDITIONS (CREDIT ADJUSTM				
5					
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL		7,015,488		
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	DEDUCTIONS (DEBIT ADJUSTM				
13	PAYOUT TO STOCKHOLDERS	725,000			
14		3			
15					
16					
17					
18	TOTAL DEDUCTIONS		725,003		
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		6,290,485		

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

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
	GENERAL INPATIENT ROUTINE CARE SERVICES			
1	00 HOSPITAL	7,121,530		7,121,530
4	00 SWING BED - SNF			
5	00 SWING BED - NF			
9	00 TOTAL GENERAL INPATIENT ROUTINE CARE	7,121,530		7,121,530
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
14	00 CHEMICAL DEPENDENCY UNIT	574,000		574,000
15	00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	574,000		574,000
16	00 TOTAL INPATIENT ROUTINE CARE SERVICE	7,695,530		7,695,530
17	00 ANCILLARY SERVICES	499,792	188,390	688,182
18	00 OUTPATIENT SERVICES		9,058,656	9,058,656
24	00			
25	00 TOTAL PATIENT REVENUES	8,195,322	9,247,046	17,442,368

PART II-OPERATING EXPENSES

26	00 OPERATING EXPENSES		8,696,790
	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		8,696,790

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

STATEMENT OF REVENUES AND EXPENSES

PROVIDER NO: 26-4012 | PERIOD: FROM 9/ 1/2009 TO 12/31/2009 | PREPARED 5/28/2010 WORKSHEET G-3

	DESCRIPTION	
1	TOTAL PATIENT REVENUES	17,442,368
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	7,892,063
3	NET PATIENT REVENUES	9,550,305
4	LESS: TOTAL OPERATING EXPENSES	8,696,790
5	NET INCOME FROM SERVICE TO PATIENTS	853,515
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	7,595
7	INCOME FROM INVESTMENTS	557
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	10,257
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	1,601
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS,FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	2,300
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER (SPECIFY)	14,961
25	TOTAL OTHER INCOME	37,271
26	TOTAL	890,786
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	890,786