

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

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	15-4041	I	FROM 1/ 1/2010	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 12/31/2010	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
					I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/ 2/2011 TIME 8:34

PART I - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
BHC MEADOWS HOSPITAL 15-4041
FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2010 AND ENDING 12/31/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
DATE: 5/ 2/2011 TIME 8:34

ZxQdtQXA:00bTUEO96ppt1Djhxyk80
tUna70:GHfGpbhsNQ57xdc9ZywKLV
IVsg0Me3I80ZUqz5

PI ENCRYPTION INFORMATION
DATE: 5/ 2/2011 TIME 8:34

r4W6rxsP1adpp0]BudLszow2s9ixP0
vVBew0z6TmdBdAPmXbCHYubGGI1Dn2
C9FV3XuBSM08fCNF

Sam J. ...
OFFICER OR ADMINISTRATOR OF PROVIDER(S)
Sr. VP & CFO
TITLE
5/11/11
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII	TITLE XIX
		1	2	3
1	HOSPITAL	-69,071	-3,374	0
100	TOTAL	-69,071	-3,374	0
				59,373
				59,373

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.

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 THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS
 (42 USC 1395g).

WORKSHEET S
 PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	15-4041	I	FROM 1/ 1/2010	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 12/31/2010	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
						--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/25/2011 TIME 15:53

PART I - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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BHC MEADOWS HOSPITAL 15-4041
 FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2010 AND ENDING 12/31/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2	3	4		
1 HOSPITAL	-69,071		-3,374		0	59,373
100 TOTAL	-69,071		-3,374		0	59,373

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS
 1 STREET: 3600 NORTH PROW ROAD P.O. BOX:
 1.01 CITY: BLOOMINGTON STATE: IN ZIP CODE: 47404- COUNTY: MONROE

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

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/1/2010 TO: 12/31/2010 1 2
 18 TYPE OF CONTROL 4
 TYPE OF HOSPITAL/SUBPROVIDER 4
 19 HOSPITAL
 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.
 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. N N
 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 1 N Y 14020
 21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 1
 21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 1
 21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION (OR APPLICABLE EXTENSION) OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105, MIPPA §147, ACA §3121 OR MMEA §108? "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 IN COL 1 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 OR MMEA §108? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. (SEE INSTRUCTIONS) N 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. 2 N
 22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N
 23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW.
 23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
 23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
 23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
 23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
 23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. / / / /
 23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
 23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
 24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY) / /
 24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). / /

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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 OR "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS) N N

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

25.07 HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THE COST REPORTING PERIOD? ENTER "Y" FOR YES OR "N" FOR NO IN COLUMN 1.

25.08 IF LINE 25.07 IS YES, ENTER IN COLUMN 1 THE WEIGHTED NUMBER OF NON-PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. 0.00

IF LINE 25.07 IS YES, USE LINES 25.09 THROUGH 25.59 AS NECESSARY TO IDENTIFY THE PROGRAM NAME IN COLUMN 1, THE PROGRAM CODE IN COLUMN 2, AND THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENTS FTES BY PROGRAM IN COLUMN 3 FOR EACH PRIMARY CARE SPECIALTY PROGRAM IN WHICH RESIDENTS ARE TRAINED. (SEE INSTRUCTIONS)

25.09 0000 0.00

26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0

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

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

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

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

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

	1	2	3	4
28.01	0	0.0000	0.0000	
28.02	0.00	0		

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

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

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

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

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

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

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

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

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

31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.01 IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.02 IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.03 IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.04 IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.05 IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

MISCELLANEOUS COST REPORT INFORMATION

- 32 IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2. N
- 33 IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO
 IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO
 YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR
 NO IN COLUMN 2 N
- 34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA? N
- 35 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N
- 35.01 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N
- 35.02 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?
- 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
 1 2 3
 N N N
 N N Y
 N N N

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

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

TITLE XIX INPATIENT SERVICES

- 38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y
- 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? Y
- 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? N
- 38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? N
- 38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? N

- 40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10?
 IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME
 OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS).

Y
 FI/CONTRACTOR #

- 40.01 NAME: FI/CONTRACTOR NAME
- 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	OUTPATIENT	OUTPATIENT
	1	2	3	4	ASC	RADIOLOGY	DIAGNOSTIC
47.00 HOSPITAL	N	N	N	N	N	N	N

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

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

MULTICAMPUS

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

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

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
					0.00

62.00

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).

MISCELLANEOUS DATA

64.00 DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO.

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-4041 I FROM 1/ 1/2010 I WORKSHEET S-3
 I TO 12/31/2010 I PART I

HOSPITAL AND HOSPITAL HEALTH CARE
 COMPLEX STATISTICAL DATA

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH N/A 2.01	I/P DAYS / TITLE V 3	O/P TITLE XVIII 4	VISITS / NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1 ADULTS & PEDIATRICS	37	13,505		282	414		383
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	37	13,505		282	414		383
6 INTENSIVE CARE UNIT							
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY				282	414		383
12 TOTAL	37	13,505		282	414		383
13 RPCH VISITS							
17 OTHER LONG TERM CARE	30	10,950					
25 TOTAL	67						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	TITLE XIX OBSERVATION BEDS ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	/ TRIPS TOTAL OBSERVATION BEDS ADMITTED 6.01	DISCHARGES TITLE XVIII NOT ADMITTED 6.02	INTERNS & RES. TOTAL 7	FTES LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			6,518				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS			6,518				
6 INTENSIVE CARE UNIT							
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY			6,518				
12 TOTAL			6,518				
13 RPCH VISITS							
17 OTHER LONG TERM CARE			10,866				
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 EMPLOYEES ON PAYROLL 10	EQUIV NONPAID WORKERS 11	TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS				36	60	59	1,107
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
6 INTENSIVE CARE UNIT							
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL		72.22		36	60	59	1,107
13 RPCH VISITS							78
17 OTHER LONG TERM CARE		32.69					
25 TOTAL		104.91					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I
I 15-4041 I
I

I PERIOD: I
I FROM 1/ 1/2010 I
I TO 12/31/2010 I

I PREPARED 5/25/2011 I
I WORKSHEET A I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					296,346
3	0300 NEW CAP REL COSTS-BLDG & FIXT		296,346	296,346		82,599
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		82,599	82,599		831,455
5	0500 EMPLOYEE BENEFITS	50,869	780,586	831,455		3,022,140
6	0600 ADMINISTRATIVE & GENERAL	1,908,336	1,063,608	2,971,944	50,196	287,203
8	0800 OPERATION OF PLANT	81,159	206,044	287,203		36,228
9	0900 LAUNDRY & LINEN SERVICE		36,228	36,228		74,498
10	1000 HOUSEKEEPING	56,959	17,539	74,498		288,708
11	1100 DIETARY	132,028	156,680	288,708		
12	1200 CAFETERIA					175,451
14	1400 NURSING ADMINISTRATION	168,760	6,691	175,451		
14.01	1401 MEDICAL ADMINISTRATION					136,304
17	1700 MEDICAL RECORDS & LIBRARY	58,856	77,448	136,304		
	INPAT ROUTINE SRVC CNTRS					1,339,579
25	2500 ADULTS & PEDIATRICS	1,571,838	46,967	1,618,805	-279,226	
26	2600 INTENSIVE CARE UNIT					
27	2700 CORONARY CARE UNIT					
28	2800 BURN INTENSIVE CARE UNIT					
29	2900 SURGICAL INTENSIVE CARE UNIT					
33	3300 NURSERY					1,193,726
36	3600 OTHER LONG TERM CARE	1,022,932	31,105	1,054,037	139,689	
	ANCILLARY SRVC COST CNTRS					32,941
44	4400 LABORATORY		32,941	32,941		159,576
56	5600 DRUGS CHARGED TO PATIENTS		160,732	160,732	-1,156	
59	3550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES					
	OUTPAT SERVICE COST CNTRS					42,093
60	6000 CLINIC	13,352	602	13,954	28,139	
61	6100 EMERGENCY					
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
	SPEC PURPOSE COST CENTERS					
90	9000 OTHER CAPITAL RELATED COSTS					7,998,847
95	SUBTOTALS	5,065,089	2,996,116	8,061,205	-62,358	
	NONREIMBURS COST CENTERS				62,358	62,358
100.01	7951 COMMUNITY RELATIONS					
100.02	7952 OUTPATIENT MEALS					
100.03	7953 CLINICAL TRIALS					
101	TOTAL	5,065,089	2,996,116	8,061,205	-0-	8,061,205

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
I 15-4041 I FROM 1/ 1/2010 I WORKSHEET A
I I TO 12/31/2010 I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	7,374	303,720
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	38,998	121,597
5	0500 EMPLOYEE BENEFITS	-65,080	766,375
6	0600 ADMINISTRATIVE & GENERAL	-241,662	2,780,478
8	0800 OPERATION OF PLANT	-4,139	283,064
9	0900 LAUNDRY & LINEN SERVICE		36,228
10	1000 HOUSEKEEPING		74,498
11	1100 DIETARY	-15,008	273,700
12	1200 CAFETERIA		
14	1400 NURSING ADMINISTRATION		175,451
14.01	1401 MEDICAL ADMINISTRATION		
17	1700 MEDICAL RECORDS & LIBRARY	-4,111	132,193
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-7,200	1,332,379
26	2600 INTENSIVE CARE UNIT		
27	2700 CORONARY CARE UNIT		
28	2800 BURN INTENSIVE CARE UNIT		
29	2900 SURGICAL INTENSIVE CARE UNIT		
33	3300 NURSERY		
36	3600 OTHER LONG TERM CARE		1,193,726
	ANCILLARY SRVC COST CNTRS		
44	4400 LABORATORY		32,941
56	5600 DRUGS CHARGED TO PATIENTS		159,576
59	3550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC		42,093
61	6100 EMERGENCY		
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
	SPEC PURPOSE COST CENTERS		
90	9000 OTHER CAPITAL RELATED COSTS		-0-
95	SUBTOTALS	-290,828	7,708,019
	NONREIMBURS COST CENTERS		
100.01	7951 COMMUNITY RELATIONS		62,358
100.02	7952 OUTPATIENT MEALS		
100.03	7953 CLINICAL TRIALS		
101	TOTAL	-290,828	7,770,377

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
14.01	MEDICAL ADMINISTRATION	1401	NURSING ADMINISTRATION
17	MEDICAL RECORDS & LIBRARY	1700	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
27	CORONARY CARE UNIT	2700	
28	BURN INTENSIVE CARE UNIT	2800	
29	SURGICAL INTENSIVE CARE UNIT	2900	
33	NURSERY	3300	
36	OTHER LONG TERM CARE	3600	
	ANCILLARY SRVC COST		
44	LABORATORY	4400	
56	DRUGS CHARGED TO PATIENTS	5600	
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	SPEC PURPOSE COST CE		
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
100.01	COMMUNITY RELATIONS	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	OUTPATIENT MEALS	7952	OTHER NONREIMBURSABLE COST CENTERS
100.03	CLINICAL TRIALS	7953	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1)	COST CENTER	LINE NO	SALARY	OTHER
	1	2	3	4	5
1 COMMUNITY RELATIONS	A	COMMUNITY RELATIONS	100.01	45,666	16,692
2 ACTIVITY THERAPY RECLASS	E	OTHER LONG TERM CARE	36	53,544	574
3 PHARMACY RECLASS	F	OTHER LONG TERM CARE	36		1,156
4 DIRECTOR OF CLINICAL SERVICES	G	OTHER LONG TERM CARE	36	84,415	
5		ADMINISTRATIVE & GENERAL	6	112,554	
6		CLINIC	60	28,139	
36 TOTAL RECLASSIFICATIONS				324,318	18,422

(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

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE		SALARY 8	OTHER 9	A-7 REF 10
			LINE NO 7				
1 COMMUNITY RELATIONS	A	ADMINISTRATIVE & GENERAL	6		45,666	16,692	
2 ACTIVITY THERAPY RECLASS	E	ADULTS & PEDIATRICS	25		53,544	574	
3 PHARMACY RECLASS	F	DRUGS CHARGED TO PATIENTS	56			1,156	
4 DIRECTOR OF CLINICAL SERVICES	G	ADULTS & PEDIATRICS	25		225,108		
5							
6							
36 TOTAL RECLASSIFICATIONS					324,318	18,422	

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

RECLASSIFICATIONS

IN LIEU OF FORM CMS-2552-96 (09/1996)
 PROVIDER NO: 154041 PERIOD: FROM 1/ 1/2010 TO 12/31/2010 PREPARED 5/25/2011 WORKSHEET A-6 NOT A CMS WORKSHEET

RECLASS CODE: A
 EXPLANATION : COMMUNITY RELATIONS

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	COMMUNITY RELATIONS	62,358
TOTAL RECLASSIFICATIONS FOR CODE A		62,358

DECREASE		
COST CENTER	LINE	AMOUNT
ADMINISTRATIVE & GENERAL	6	62,358

RECLASS CODE: E
 EXPLANATION : ACTIVITY THERAPY RECLASS

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	OTHER LONG TERM CARE	54,118
TOTAL RECLASSIFICATIONS FOR CODE E		54,118

DECREASE		
COST CENTER	LINE	AMOUNT
ADULTS & PEDIATRICS	25	54,118

RECLASS CODE: F
 EXPLANATION : PHARMACY RECLASS

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	OTHER LONG TERM CARE	1,156
TOTAL RECLASSIFICATIONS FOR CODE F		1,156

DECREASE		
COST CENTER	LINE	AMOUNT
DRUGS CHARGED TO PATIENTS	56	1,156

RECLASS CODE: G
 EXPLANATION : DIRECTOR OF CLINICAL SERVICES

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	OTHER LONG TERM CARE	84,415
2.00	ADMINISTRATIVE & GENERAL	112,554
3.00	CLINIC	28,139
TOTAL RECLASSIFICATIONS FOR CODE G		225,108

DECREASE		
COST CENTER	LINE	AMOUNT
ADULTS & PEDIATRICS	25	225,108
		0
		0
		225,108

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

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

DESCRIPTION

SUMMARY OF OLD AND NEW CAPITAL

*	DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	TOTAL (1)
								15
3	NEW CAP REL COSTS-BL	212,290	8,400		16,295	66,735		303,720
4	NEW CAP REL COSTS-MV	50,735	70,862					121,597
5	TOTAL	263,025	79,262		16,295	66,735		425,317

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

DESCRIPTION

SUMMARY OF OLD AND NEW CAPITAL

*	DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	TOTAL (1)
								15
3	NEW CAP REL COSTS-BL	204,916	8,400		16,295	66,735		296,346
4	NEW CAP REL COSTS-MV	11,737	70,862					82,599
5	TOTAL	216,653	79,262		16,295	66,735		378,945

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

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	6	ADMINISTRATIVE & GENERAL	HOME OFFICE COSTS	259,898	243,422	16,476
2	6	ADMINISTRATIVE & GENERAL	INTEREST		19,505	-19,505
3						
4						
5		TOTALS		259,898	262,927	-3,029

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

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

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

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

(1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-4041 I FROM 1/ 1/2010 I WORKSHEET A-8-2
 I I TO 12/31/2010 I GROUP 1

1	2	3	4	5	6	7	8	9
WKSHT A	COST CENTER/	TOTAL	PROFES-	PROVIDER	RCE	PHYSICIAN/	UNADJUSTED	5 PERCENT OF
LINE NO.	PHYSICIAN	REMUN-	SIONAL	COMPONENT	AMOUNT	PROVIDER	RCE LIMIT	UNADJUSTED
1	IDENTIFIER	ERATION	COMPONENT	5	6	COMPONENT	8	RCE LIMIT
6	2	3	4			HOURS		9
1								
2	6	91,100	91,100					
3	25	7,200	7,200					
4								
5								
6								
7								
8								
9								
10								
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18								
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21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	98,300	98,300					

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO:
I 15-4041
I

I PERIOD:
I FROM 1/ 1/2010
I TO 12/31/2010

I PREPARED 5/25/2011
I WORKSHEET A-8-2
I GROUP 1

LINE NO.	WKSHT A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF COL 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COL 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
			12	13	14	15	16	17	18
1	6	AGGREGATE							91,100
2	25	AGGREGATE							7,200
3									
4									
5									
6									
7									
8									
9									
10									
11									
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17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL							98,300

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
	0	3	4	5	5a.00	6	8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	303,720	303,720					
005 NEW CAP REL COSTS-MVBLE E	121,597		121,597				
006 EMPLOYEE BENEFITS	766,375	1,809	724	768,908			
008 ADMINISTRATIVE & GENERAL	2,780,478	46,737	18,712	302,893	3,148,820	3,148,820	
009 OPERATION OF PLANT	283,064	8,143	3,260	12,445	306,912	209,109	516,021
010 LAUNDRY & LINEN SERVICE	36,228	6,605	2,644		45,477	30,985	13,797
011 HOUSEKEEPING	74,498	6,685	2,676	8,734	92,593	63,087	13,964
012 DIETARY	273,700	28,356	11,353	20,246	333,655	227,330	59,233
014 CAFETERIA				25,879	203,874	138,906	3,795
014 01 NURSING ADMINISTRATION	175,451	1,817	727		6,974	4,752	10,402
017 01 MEDICAL ADMINISTRATION		4,980	1,994		147,076	100,208	8,738
017 03 MEDICAL RECORDS & LIBRARY	132,193	4,183	1,675	9,025			
025 INPAT ROUTINE SRVC CNTRS	1,332,379	94,956	38,017	198,304	1,663,656	1,133,504	198,353
026 ADULTS & PEDIATRICS							
027 INTENSIVE CARE UNIT							
028 CORONARY CARE UNIT							
029 BURN INTENSIVE CARE UNIT							
033 SURGICAL INTENSIVE CARE U							
036 NURSERY	1,193,726	98,588	39,471	178,017	1,509,802	1,028,678	205,941
044 OTHER LONG TERM CARE							
056 ANCILLARY SRVC COST CNTRS	32,941	590	236		33,767	23,007	1,232
059 LABORATORY	159,576				159,576	108,724	
060 DRUGS CHARGED TO PATIENTS							
061 PSYCHIATRIC/PSYCHOLOGICAL							
062 OUTPAT SERVICE COST CNTRS	42,093			6,362	48,455	33,014	
095 CLINIC							
EMERGENCY							
OBSERVATION BEDS (NON-DIS							
SPEC PURPOSE COST CENTERS	7,708,019	303,449	121,489	761,905	7,700,637	3,101,304	515,455
NONREIMBURS COST CENTERS	62,358	271	108	7,003	69,740	47,516	566
100 01 COMMUNITY RELATIONS							
100 02 OUTPATIENT MEALS							
100 03 CLINICAL TRIALS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	7,770,377	303,720	121,597	768,908	7,770,377	3,148,820	516,021

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL ADMIN ISTRATION	MEDICAL ADMIN	MEDICAL RECOR DS & LIBRARY
	9	10	11	12	14	14.01	17	
003 GENERAL SERVICE COST CNTR								
004 NEW CAP REL COSTS-BLDG &								
005 NEW CAP REL COSTS-MVBLE E								
006 EMPLOYEE BENEFITS								
008 ADMINISTRATIVE & GENERAL								
009 OPERATION OF PLANT								
010 LAUNDRY & LINEN SERVICE	90,259							
011 HOUSEKEEPING		169,644						
012 DIETARY		20,580	640,798					
014 CAFETERIA			78,235	78,235				
014 NURSING ADMINISTRATION		1,318		3,113	351,006			
014 01 MEDICAL ADMINISTRATION		3,614				25,742		
017 MEDICAL RECORDS & LIBRARY		3,036		2,148				261,206
025 INPAT ROUTINE SRVC CNTRS								
026 ADULTS & PEDIATRICS	33,842	68,917	210,807	34,669	169,450	25,742		169,760
027 INTENSIVE CARE UNIT								
028 CORONARY CARE UNIT								
029 BURN INTENSIVE CARE UNIT								
033 SURGICAL INTENSIVE CARE U								
036 NURSERY								85,397
044 OTHER LONG TERM CARE	56,417	71,554	351,453	37,146	181,556			
056 ANCILLARY SRVC COST CNTRS		428						1,726
059 LABORATORY								3,729
060 DRUGS CHARGED TO PATIENTS								
061 PSYCHIATRIC/PSYCHOLOGICAL								
062 OUTPAT SERVICE COST CNTRS								594
095 CLINIC				303				
100 01 EMERGENCY								
100 02 OBSERVATION BEDS (NON-DIS								
100 03 SPEC PURPOSE COST CENTERS								
101 SUBTOTALS	90,259	169,447	640,798	77,076	351,006	25,742		261,206
102 NONREIMBURS COST CENTERS								
103 TOTAL		197		1,159				
100 01 COMMUNITY RELATIONS								
100 02 OUTPATIENT MEALS								
100 03 CLINICAL TRIALS								
101 CROSS FOOT ADJUSTMENT								
102 NEGATIVE COST CENTER								
103 TOTAL	90,259	169,644	640,798	78,235	351,006	25,742		261,206

COST ALLOCATION - GENERAL SERVICE COSTS

	COST CENTER DESCRIPTION	SUBTOTAL	I&R COST POST STEP-DOWN ADJ 26	TOTAL
		25		27
	GENERAL SERVICE COST CNTR			
003	NEW CAP REL COSTS-BLDG &			
004	NEW CAP REL COSTS-MVBLE E			
005	EMPLOYEE BENEFITS			
006	ADMINISTRATIVE & GENERAL			
008	OPERATION OF PLANT			
009	LAUNDRY & LINEN SERVICE			
010	HOUSEKEEPING			
011	DIETARY			
012	CAFETERIA			
014	NURSING ADMINISTRATION			
014 01	MEDICAL ADMINISTRATION			
017	MEDICAL RECORDS & LIBRARY			
	INPAT ROUTINE SRVC CNTRS			
025	ADULTS & PEDIATRICS	3,708,700		3,708,700
026	INTENSIVE CARE UNIT			
027	CORONARY CARE UNIT			
028	BURN INTENSIVE CARE UNIT			
029	SURGICAL INTENSIVE CARE U			
033	NURSERY			
036	OTHER LONG TERM CARE	3,527,944		3,527,944
	ANCILLARY SRVC COST CNTRS			
044	LABORATORY	60,160		60,160
056	DRUGS CHARGED TO PATIENTS	272,029		272,029
059	PSYCHIATRIC/PSYCHOLOGICAL			
	OUTPAT SERVICE COST CNTRS			
060	CLINIC	82,366		82,366
061	EMERGENCY			
062	OBSERVATION BEDS (NON-DIS			
	SPEC PURPOSE COST CENTERS			
095	SUBTOTALS	7,651,199		7,651,199
	NONREIMBURS COST CENTERS			
100 01	COMMUNITY RELATIONS	119,178		119,178
100 02	OUTPATIENT MEALS			
100 03	CLINICAL TRIALS			
101	CROSS FOOT ADJUSTMENT			
102	NEGATIVE COST CENTER			
103	TOTAL	7,770,377		7,770,377

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	DIR ASSIGNED NEW CAPITAL REL COSTS 0	NEW CAP REL COSTS-BLDG & OSTS 3	NEW CAP REL COSTS-MVBLE E OSTS 4	SUBTOTAL 4a	EMPLOYEE BENE FITS 5	ADMINISTRATIVE & GENERAL 6	OPERATION OF PLANT 8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG & NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS		1,809	724	2,533	2,533		
006 ADMINISTRATIVE & GENERAL	15,875	46,737	18,712	81,324	998	82,322	16,911
008 OPERATION OF PLANT		8,143	3,260	11,403	41	5,467	452
009 LAUNDRY & LINEN SERVICE		6,605	2,644	9,249		810	458
010 HOUSEKEEPING		6,685	2,676	9,361	29	1,649	1,941
011 DIETARY		28,356	11,353	39,709	67	5,943	
012 CAFETERIA							124
014 NURSING ADMINISTRATION		1,817	727	2,544	85	3,632	341
014 01 MEDICAL ADMINISTRATION		4,980	1,994	6,974		124	286
017 MEDICAL RECORDS & LIBRARY		4,183	1,675	5,858		2,620	
025 INPAT ROUTINE SRVC CNTRS							6,500
025 ADULTS & PEDIATRICS		94,956	38,017	132,973	653	29,634	
026 INTENSIVE CARE UNIT							
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
033 NURSERY							6,750
036 OTHER LONG TERM CARE		98,588	39,471	138,059	586	26,894	
044 ANCILLARY SRVC COST CNTRS							40
044 LABORATORY		590	236	826		601	
056 DRUGS CHARGED TO PATIENTS						2,843	
059 PSYCHIATRIC/PSYCHOLOGICAL							
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC						21	863
061 EMERGENCY							
062 OBSERVATION BEDS (NON-DIS							
095 SPEC PURPOSE COST CENTERS	15,875	303,449	121,489	440,813	2,510	81,080	16,892
095 SUBTOTALS							
100 NONREIMBURS COST CENTERS							19
100 01 COMMUNITY RELATIONS		271	108	379	23	1,242	
100 02 OUTPATIENT MEALS							
100 03 CLINICAL TRIALS							
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER	15,875	303,720	121,597	441,192	2,533	82,322	16,911
103 TOTAL							

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL ADMIN ISTRATION	MEDICAL ADMIN	MEDICAL RECOR DS & LIBRARY
	9	10	11	12	14	14.01	17	
003 GENERAL SERVICE COST CNTR								
004 NEW CAP REL COSTS-BLDG &								
005 NEW CAP REL COSTS-MVBLE E								
006 EMPLOYEE BENEFITS								
008 ADMINISTRATIVE & GENERAL								
009 OPERATION OF PLANT								
010 LAUNDRY & LINEN SERVICE	10,511							
011 HOUSEKEEPING		11,497						
012 DIETARY		1,395	49,055					
012 CAFETERIA			5,989	5,989				
014 NURSING ADMINISTRATION		89			6,712			
014 01 MEDICAL ADMINISTRATION		245				7,684		
017 MEDICAL RECORDS & LIBRARY		206		164				9,164
025 INPAT ROUTINE SRVC CNTRS								
026 ADULTS & PEDIATRICS	3,941	4,671	16,138	2,654	3,240	7,684		5,952
027 INTENSIVE CARE UNIT								
027 CORONARY CARE UNIT								
028 BURN INTENSIVE CARE UNIT								
029 SURGICAL INTENSIVE CARE U								
033 NURSERY								2,999
036 OTHER LONG TERM CARE	6,570	4,849	26,905	2,844	3,472			
044 ANCILLARY SRVC COST CNTRS								61
056 LABORATORY		29						131
059 DRUGS CHARGED TO PATIENTS								
060 PSYCHIATRIC/PSYCHOLOGICAL								
061 OUTPAT SERVICE COST CNTRS								21
062 CLINIC			23					
062 EMERGENCY								
062 OBSERVATION BEDS (NON-DIS								
062 SPEC PURPOSE COST CENTERS								
095 SUBTOTALS	10,511	11,484	49,055	5,900	6,712	7,684		9,164
100 01 NONREIMBURS COST CENTERS								
100 02 COMMUNITY RELATIONS		13		89				
100 03 OUTPATIENT MEALS								
101 CLINICAL TRIALS								
102 CROSS FOOT ADJUSTMENTS								
103 NEGATIVE COST CENTER								
103 TOTAL	10,511	11,497	49,055	5,989	6,712	7,684		9,164

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION		SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		25	26	27
	GENERAL SERVICE COST CNTR			
003	NEW CAP REL COSTS-BLDG &			
004	NEW CAP REL COSTS-MVBLE E			
005	EMPLOYEE BENEFITS			
006	ADMINISTRATIVE & GENERAL			
008	OPERATION OF PLANT			
009	LAUNDRY & LINEN SERVICE			
010	HOUSEKEEPING			
011	DIETARY			
012	CAFETERIA			
014	NURSING ADMINISTRATION			
014	01 MEDICAL ADMINISTRATION			
017	MEDICAL RECORDS & LIBRARY			
	INPAT ROUTINE SRVC CNTRS			
025	ADULTS & PEDIATRICS	214,040		214,040
026	INTENSIVE CARE UNIT			
027	CORONARY CARE UNIT			
028	BURN INTENSIVE CARE UNIT			
029	SURGICAL INTENSIVE CARE U			
033	NURSERY			
036	OTHER LONG TERM CARE	219,928		219,928
	ANCILLARY SRVC COST CNTRS			
044	LABORATORY	1,557		1,557
056	DRUGS CHARGED TO PATIENTS	2,974		2,974
059	PSYCHIATRIC/PSYCHOLOGICAL			
	OUTPAT SERVICE COST CNTRS			
060	CLINIC	928		928
061	EMERGENCY			
062	OBSERVATION BEDS (NON-DIS			
	SPEC PURPOSE COST CENTERS			
095	SUBTOTALS	439,427		439,427
	NONREIMBURS COST CENTERS			
100	01 COMMUNITY RELATIONS	1,765		1,765
100	02 OUTPATIENT MEALS			
100	03 CLINICAL TRIALS			
101	CROSS FOOT ADJUSTMENTS			
102	NEGATIVE COST CENTER			
103	TOTAL	441,192		441,192

COMPUTATION OF RATIO OF COSTS TO CHARGES

I
I
I

PROVIDER NO:
15-4041

I PERIOD:
I FROM 1/ 1/2010
I TO 12/31/2010

I PREPARED 5/25/2011
I WORKSHEET C
I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	3,708,700		3,708,700		3,708,700
26	INTENSIVE CARE UNIT					
27	CORONARY CARE UNIT					
28	BURN INTENSIVE CARE UNIT					
29	SURGICAL INTENSIVE CARE U					
33	NURSERY					
36	OTHER LONG TERM CARE	3,527,944		3,527,944		3,527,944
	ANCILLARY SRVC COST CNTRS					
44	LABORATORY	60,160		60,160		60,160
56	DRUGS CHARGED TO PATIENTS	272,029		272,029		272,029
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS					
60	CLINIC	82,366		82,366		82,366
61	EMERGENCY					
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	7,651,199		7,651,199		7,651,199
102	LESS OBSERVATION BEDS					
103	TOTAL	7,651,199		7,651,199		7,651,199

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	12,420,906		12,420,906			
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
33	NURSERY						
36	OTHER LONG TERM CARE	6,247,950		6,247,950			
44	ANCILLARY SRVC COST CNTRS						
44	LABORATORY	126,285		126,285	.476383	.476383	.476383
56	DRUGS CHARGED TO PATIENTS	272,799		272,799	.997177	.997177	.997177
59	PSYCHIATRIC/PSYCHOLOGICAL						
60	OUTPAT SERVICE COST CNTRS						
60	CLINIC	25,585	17,905	43,490	1.893907	1.893907	1.893907
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
62	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	19,093,525	17,905	19,111,430			
102	LESS OBSERVATION BEDS						
103	TOTAL	19,093,525	17,905	19,111,430			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
44	ANCILLARY SRVC COST CNTRS						60,160
56	LABORATORY	60,160	1,557	58,603			
59	DRUGS CHARGED TO PATIENTS	272,029	2,974	269,055			272,029
60	PSYCHIATRIC/PSYCHOLOGICAL						
61	OUTPAT SERVICE COST CNTRS						
62	CLINIC	82,366	928	81,438			82,366
101	EMERGENCY						
102	OBSERVATION BEDS (NON-DIS						
103	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	414,555	5,459	409,096			414,555
102	LESS OBSERVATION BEDS						
103	TOTAL	414,555	5,459	409,096			414,555

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
44	ANCILLARY SRVC COST CNTRS			
	LABORATORY	126,285	.476383	.476383
56	DRUGS CHARGED TO PATIENTS	272,799	.997177	.997177
59	PSYCHIATRIC/PSYCHOLOGICAL			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	43,490	1.893907	1.893907
61	EMERGENCY			
62	OBSERVATION BEDS (NON-DIS			
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	442,574		
102	LESS OBSERVATION BEDS			
103	TOTAL	442,574		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-4041 I FROM 1/ 1/2010 I WORKSHEET D
 I I TO 12/31/2010 I PART I

TITLE XVIII, PART A

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
		CAPITAL REL COST (B, II) 1	SWING BED ADJUSTMENT 2	REDUCED CAP RELATED COST 3	CAPITAL REL COST (B, III) 4	SWING BED ADJUSTMENT 5	REDUCED CAP RELATED COST 6
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS				214,040		214,040
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
33	NURSERY						
101	TOTAL				214,040		214,040

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-4041 I FROM 1/ 1/2010 I WORKSHEET D
 I I TO 12/31/2010 I PART I
 PPS

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

TITLE XVIII, PART A

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	INPAT PROGRAM OLD CAP CST 10	NEW CAPITAL PER DIEM 11	INPAT PROGRAM NEW CAP CST 12
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	6,518	414			32.84	13,596
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
33	NURSERY						
101	TOTAL	6,518	414				13,596

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-4041 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART II
 I 15-4041 I

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	OLD CAPITAL CST/CHRG RATIO 5	CAPITAL COSTS 6
44	ANCILLARY SRVC COST CNTRS LABORATORY		1,557	126,285	10,573		
56	DRUGS CHARGED TO PATIENTS		2,974	272,799	33,322		
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS						
60	CLINIC		928	43,490			
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS						
101	TOTAL		5,459	442,574	43,895		

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WKST A LINE NO.	TITLE XVIII, PART A COST CENTER DESCRIPTION	HOSPITAL	
		NEW CAPITAL CST/CHRG 7	RATIO RATIO 8
44	ANCILLARY SRVC COST CNTRS LABORATORY	.012329	130
56	DRUGS CHARGED TO PATIENTS	.010902	363
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS		
60	CLINIC	.021338	
61	EMERGENCY		
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS		
101	TOTAL		493

IN LIEU OF FORM CMS-2552-96(09/1996) CONTD
 I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-4041 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART II
 I 15-4041 I
 PPS

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)	6,518
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,518
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,518
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)	414
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,708,700
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	3,708,700
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	12,420,906
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	12,420,906
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.298585
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,905.63
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3,708,700

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-4041 I FROM 1/ 1/2010 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2010 I PART II
 I 15-4041 I I

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 568.99
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 235,562
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 235,562

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
INTENSIVE CARE TYPE INPATIENT					
HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					1
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					38,265
49 TOTAL PROGRAM INPATIENT COSTS					273,827

PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES 13,596
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES 493
 52 TOTAL PROGRAM EXCLUDABLE COST 14,089
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN
 ANESTHETIST, AND MEDICAL EDUCATION COSTS 259,738

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

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-4041 I FROM 1/ 1/2010 I WORKSHEET D-1
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 I 15-4041 I I

COMPUTATION OF INPATIENT OPERATING COST

TITLE XVIII PART A HOSPITAL PPS

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

1

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

PART IV - COMPUTATION OF OBSERVATION BED COST

- 83 TOTAL OBSERVATION BED DAYS
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 568.99
- 85 OBSERVATION BED COST

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86 OLD CAPITAL-RELATED COST		3,708,700			
87 NEW CAPITAL-RELATED COST	214,040	3,708,700	.057713		
88 NON PHYSICIAN ANESTHETIST		3,708,700			
89 MEDICAL EDUCATION		3,708,700			
89.01 MEDICAL EDUCATION - ALLIED HEA					
89.02 MEDICAL EDUCATION - ALL OTHER					

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/25/2011
I	15-4041	I	FROM 1/ 1/2010	I	WORKSHEET D-1	
I	COMPONENT NO:	I	TO 12/31/2010	I	PART I	
I	15-4041	I		I		

COMPUTATION OF INPATIENT OPERATING COST

TITLE XIX - I/P	HOSPITAL	OTHER
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PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	6,518
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,518
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,518
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)	383
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,708,700
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	3,708,700
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	12,420,906
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	12,420,906
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.298585
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,905.63
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	3,708,700
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-4041 I FROM 1/ 1/2010 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2010 I PART II
 I 15-4041 I I

COMPUTATION OF INPATIENT OPERATING COST

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 568.99
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 217,923
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 217,923

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
43 INTENSIVE CARE TYPE INPATIENT					
44 HOSPITAL UNITS					
45 INTENSIVE CARE UNIT					
46 CORONARY CARE UNIT					
47 BURN INTENSIVE CARE UNIT					
48 SURGICAL INTENSIVE CARE UNIT					
49 OTHER SPECIAL CARE					1
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					12,653
49 TOTAL PROGRAM INPATIENT COSTS					230,576

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

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
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COMPUTATION OF INPATIENT OPERATING COST

TITLE XIX - I/P HOSPITAL OTHER

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

1

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

PART IV - COMPUTATION OF OBSERVATION BED COST

- 83 TOTAL OBSERVATION BED DAYS
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 568.99
- 85 OBSERVATION BED COST

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
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 I COMPONENT NO: I TO 12/31/2010 I
 I 15-4041 I

TITLE XVIII, PART A HOSPITAL

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		786,400	
26	INTENSIVE CARE UNIT			
27	CORONARY CARE UNIT			
28	BURN INTENSIVE CARE UNIT			
29	SURGICAL INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
44	LABORATORY	.476383	10,573	5,037
56	DRUGS CHARGED TO PATIENTS	.997177	33,322	33,228
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	1.893907		
61	EMERGENCY			
62	OBSERVATION BEDS (NON-DISTINCT PART)			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		43,895	38,265
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		43,895	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

IN LIEU OF FORM CMS-2552-96 (11/1998)
 I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-4041 I FROM 1/ 1/2010 I WORKSHEET E-1
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TITLE XVIII HOSPITAL

DESCRIPTION

INPATIENT-PART A P A R T B
 MM/DD/YYYY AMOUNT MM/DD/YYYY AMOUNT
 1 2 3 4

- 1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER
- 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.
- 3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)

ADJUSTMENTS TO PROVIDER .01
 ADJUSTMENTS TO PROVIDER .02
 ADJUSTMENTS TO PROVIDER .03
 ADJUSTMENTS TO PROVIDER .04
 ADJUSTMENTS TO PROVIDER .05
 ADJUSTMENTS TO PROGRAM .50
 ADJUSTMENTS TO PROGRAM .51
 ADJUSTMENTS TO PROGRAM .52
 ADJUSTMENTS TO PROGRAM .53
 ADJUSTMENTS TO PROGRAM .54
 ADJUSTMENTS TO PROGRAM .99

NONE NONE

NONE NONE

231,358

- 4 TOTAL INTERIM PAYMENTS

- 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
 TENTATIVE TO PROGRAM .99

NONE NONE

- 6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)
- 7 TOTAL MEDICARE PROGRAM LIABILITY

SETTLEMENT TO PROVIDER .01
 SETTLEMENT TO PROGRAM .02

3,374

227,984

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.

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
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CALCULATION OF REIMBURSEMENT SETTLEMENT

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

1	INPATIENT HOSPITAL SERVICES (SEE INSTRUCTIONS)	
1.01	HOSPITAL SPECIFIC AMOUNT (SEE INSTRUCTIONS)	
1.02	ENTER FROM THE PS&R, THE IRF PPS PAYMENT	
1.03	MEDICARE SSI RATIO (IRF PPS ONLY) (SEE INSTR.)	
1.04	INPATIENT REHABILITATION FACILITY LIP PAYMENTS (SEE INSTRUCTIONS)	
1.05	OUTLIER PAYMENTS	
1.06	TOTAL PPS PAYMENTS (SUM OF LINES 1.01, (1.02, 1.04 FOR COLUMNS 1 & 1.01), 1.05 AND 1.42)	
1.07	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)	
1.08	INPATIENT PSYCHIATRIC FACILITY (IPF) NET FEDERAL IPF PPS PAYMENTS (EXCLUDING OUTLIER, ECT, STOP-LOSS, AND MEDICAL EDUCATION PAYMENTS)	266,387
1.09	NET IPF PPS OUTLIER PAYMENTS	
1.10	NET IPF PPS ECT PAYMENTS	
1.11	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR LATEST COST REPORT FILED PRIOR TO NOVEMBER 15, 2004 (SEE INSTRUCTIONS)	
1.12	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)	
1.13	CURRENT YEARS UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.14	CURRENT YEARS UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.15	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.16	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	17.857534
1.17	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{((1 + (\text{LINE } 1.15/\text{1.16})) \text{ RAISED TO THE POWER OF } .5150 - 1)\}$.	
1.18	MEDICAL EDUCATION ADJUSTMENT (LINE 1.08 MULTIPLIED BY LINE 1.17).	
1.19	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1.08, 1.09, 1.10 AND 1.18)	266,387
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)	266,387
1.35	INPATIENT REHABILITATION FACILITY (IRF) 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 (SEE INSTRUCTIONS)	
1.42	MEDICAL EDUCATION ADJUSTMENT (LINE 1.02 MULTIPLIED BY LINE 1.41).	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	266,387
4	SUBTOTAL (SEE INSTRUCTIONS)	1,993
5	PRIMARY PAYER PAYMENTS	264,394
6	SUBTOTAL	52,736
7	DEDUCTIBLES	211,658
8	SUBTOTAL	1,100
9	COINSURANCE	210,558
10	SUBTOTAL	24,894
11	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROF SERV)	17,426
11.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
11.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	227,984
12	SUBTOTAL	
13	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
13.01	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)	
14	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
15	OTHER ADJUSTMENTS (SPECIFY)	
15.99	OUTLIER RECONCILIATION ADJUSTMENT	
16	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/25/2011
I	15-4041	I	FROM 1/ 1/2010	I	WORKSHEET	E-3
I	COMPONENT NO:	I	TO 12/31/2010	I	PART I	
I	15-4041	I		I		

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

17	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	227,984
18	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
19	INTERIM PAYMENTS	231,358
19.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
20	BALANCE DUE PROVIDER/PROGRAM	-3,374
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

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

50	ORIGINAL PPS AMOUNT OR ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS).
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS).

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
1	COMPUTATION OF NET COST OF COVERED SERVICE			
2	INPATIENT HOSPITAL/SNF/NF SERVICES		230,576	
3	MEDICAL AND OTHER SERVICES			
4	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			
5	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)			
6	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			
7	SUBTOTAL		230,576	
8	INPATIENT PRIMARY PAYER PAYMENTS			
9	OUTPATIENT PRIMARY PAYER PAYMENTS		230,576	
	SUBTOTAL			
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
10	ROUTINE SERVICE CHARGES		728,900	
11	ANCILLARY SERVICE CHARGES		14,552	
12	INTERNS AND RESIDENTS SERVICE CHARGES			
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE			
14	TEACHING PHYSICIANS			
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION			
16	TOTAL REASONABLE CHARGES		743,452	
	CUSTOMARY CHARGES			
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR			
18	PAYMENT FOR SERVICES ON A CHARGE BASIS			
19	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE			
20	FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT			
21	BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			
22	RATIO OF LINE 17 TO LINE 18			
23	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		743,452	
24	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		512,876	
25	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
26	COST OF COVERED SERVICES		230,576	
	PROSPECTIVE PAYMENT AMOUNT			
27	OTHER THAN OUTLIER PAYMENTS			
28	OUTLIER PAYMENTS			
29	PROGRAM CAPITAL PAYMENTS			
30	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			
31	ROUTINE SERVICE OTHER PASS THROUGH COSTS			
32	ANCILLARY SERVICE OTHER PASS THROUGH COSTS			
33	SUBTOTAL		230,576	
34	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)			
35	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE		230,576	
36	XVIII ENTER AMOUNT FROM LINE 30			
37	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
38	EXCESS OF REASONABLE COST		230,576	
39	SUBTOTAL			
40	COINSURANCE			
41	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19			
42	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			
43	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING			
44	BEFORE 10/01/05 (SEE INSTRUCTIONS)			
45	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			
46	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING			
47	ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)			
48	UTILIZATION REVIEW			
49	SUBTOTAL (SEE INSTRUCTIONS)		230,576	
50	INPATIENT ROUTINE SERVICE COST			
51	MEDICARE INPATIENT ROUTINE CHARGES			
52	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR			
53	PAYMENT FOR SERVICES ON A CHARGE BASIS			
54	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE			
55	FOR PAYMENT OF PART A SERVICES			
56	RATIO OF LINE 43 TO 44			
57	TOTAL CUSTOMARY CHARGES			
58	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
59	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
60	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER			
61	TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			
62	OTHER ADJUSTMENTS (SPECIFY)			
63	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS			
64	RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			
65	SUBTOTAL		230,576	
66	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
67	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			
68	TOTAL AMOUNT PAYABLE TO THE PROVIDER		230,576	
69	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
70	INTERIM PAYMENTS		171,203	
71	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			
72	BALANCE DUE PROVIDER/PROGRAM		59,373	
73	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)			

CALCULATION OF REIMBURSEMENT SETTLEMENT

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

		IN LIEU OF FORM CMS-2552-96-E-3 (5/2008)	
I	PROVIDER NO:	I PERIOD:	I PREPARED 5/25/2011
I	15-4041	I FROM 1/ 1/2010	I WORKSHEET E-3
I	COMPONENT NO:	I TO 12/31/2010	I PART III
I	-	I	I

TITLE XIX

HOSPITAL

OTHER
TITLE V OR
TITLE XIX
1

TITLE XVIII
SNF PPS
2

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

BALANCE SHEET

I
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I

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	-4,725			
2 TEMPORARY INVESTMENTS				
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	998,201			
5 OTHER RECEIVABLES				
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-131,269			
7 INVENTORY				
8 PREPAID EXPENSES				
9 OTHER CURRENT ASSETS	-152,070			
10 DUE FROM OTHER FUNDS				
11 TOTAL CURRENT ASSETS	710,137			
FIXED ASSETS				
12 LAND	310,000			
12.01 LAND IMPROVEMENTS				
13.01 LESS ACCUMULATED DEPRECIATION				
14 BUILDINGS	3,198,949			
14.01 LESS ACCUMULATED DEPRECIATION	-15,995			
15 LEASEHOLD IMPROVEMENTS				
15.01 LESS ACCUMULATED DEPRECIATION				
16 FIXED EQUIPMENT				
16.01 LESS ACCUMULATED DEPRECIATION				
17 AUTOMOBILES AND TRUCKS				
17.01 LESS ACCUMULATED DEPRECIATION				
18 MAJOR MOVABLE EQUIPMENT	259,286			
18.01 LESS ACCUMULATED DEPRECIATION	-8,102			
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE	54,800			
21 TOTAL FIXED ASSETS	3,798,938			
OTHER ASSETS				
22 INVESTMENTS				
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS	-4,201,329			
26 TOTAL OTHER ASSETS	-4,201,329			
27 TOTAL ASSETS	307,746			

I
I
I

PROVIDER NO:
15-4041

I PERIOD:
I FROM 1/ 1/2010
I TO 12/31/2010

I PREPARED 5/25/2011

I WORKSHEET G

BALANCE SHEET

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE			
	64,723			
29	SALARIES, WAGES & FEES PAYABLE			
	199,277			
30	PAYROLL TAXES PAYABLE			
31	NOTES AND LOANS PAYABLE (SHORT TERM)			
32	DEFERRED INCOME			
33	ACCELERATED PAYMENTS			
34	DUE TO OTHER FUNDS			
35	OTHER CURRENT LIABILITIES			
	134,282			
36	TOTAL CURRENT LIABILITIES			
	398,282			
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			
	24,780			
42	TOTAL LONG-TERM LIABILITIES			
	24,780			
43	TOTAL LIABILITIES			
	423,062			
CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE			
	-115,316			
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			
	-115,316			
52	TOTAL LIABILITIES AND FUND BALANCES			
	307,746			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING		84,348		
2 OF PERIOD				
3 NET INCOME (LOSS)		-199,664		
4 TOTAL		-115,316		
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
6 ADDITIONS (CREDIT ADJUSTM				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL		-115,316		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM				
14				
15				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF		-115,316		
PERIOD PER BALANCE SHEET				

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-4041 I FROM 1/ 1/2010 I WORKSHEET G-2
 I I TO 12/31/2010 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	18,632,150		18,632,150
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
8 00 OTHER LONG TERM CARE			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	18,632,150		18,632,150
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT			
11 00 CORONARY CARE UNIT			
12 00 BURN INTENSIVE CARE UNIT			
13 00 SURGICAL INTENSIVE CARE UNIT			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	18,632,150		18,632,150
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE			695,426
17 00 ANCILLARY SERVICES	695,426		695,426
18 00 OUTPATIENT SERVICES	1,630,299		1,630,299
24 00			
25 00 TOTAL PATIENT REVENUES	20,957,875		20,957,875

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		8,061,205	
ADD (SPECIFY)			
27 00 BAD DEBTS	73,307		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		73,307	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		8,134,512	

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011
 I 15-4041 I FROM 1/ 1/2010 I WORKSHEET G-3
 I I TO 12/31/2010 I

DESCRIPTION		
1	TOTAL PATIENT REVENUES	20,957,875
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	13,043,157
3	NET PATIENT REVENUES	7,914,718
4	LESS: TOTAL OPERATING EXPENSES	8,134,512
5	NET INCOME FROM SERVICE TO PATIENTS	-219,794
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER INCOME	20,130
25	TOTAL OTHER INCOME	20,130
26	TOTAL	-199,664
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	-199,664