

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

WORKSHEET S  
 PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I PERIOD	I INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	26-4012	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	I --FINAL 1-MCR CODE	I	
				I 00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/25/2011 TIME 11:15

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: CENTERPOINE HOSPITAL 26-4012 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.

*Susan M Mathis*  
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)  
*Chief Operating Officer*  
 TITLE  
*May 27, 2011*  
 DATE

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 ECR ENCRYPTION INFORMATION  
 DATE: 5/25/2011 TIME 11:15

bxdl1lErFqFkyHhuRHPo.bpRJBX:0  
 wnTCD0tMUMJgItbKbw3EdjcQbJT0HH  
 mVeL0Kc1se0jSGca

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 PI ENCRYPTION INFORMATION  
 DATE: 5/25/2011 TIME 11:15

vHiAfXqGu1ldySGvmE58kIiXOGd0m0  
 6q07t0FIpwtM:dvmuvBsc87jZJX9r2  
 eja62CDK:H0jAxoz

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX
	1	2	3	4	
1 HOSPITAL	0	46,295	55,271	339,032	
100 TOTAL	0	46,295	55,271	339,032	

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

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

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

FORM APPROVED  
OMB NO. 0938-0050

WORKSHEET S  
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	26-4012	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 11:19

PART I - CERTIFICATION

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

CENTERPOINE HOSPITAL 26-4012  
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.

*Susan M Mathis*  
\_\_\_\_\_  
OFFICER OR ADMINISTRATOR OF PROVIDER(S)  
*Chief Operating Officer*  
\_\_\_\_\_  
TITLE  
*May 27, 2011*  
\_\_\_\_\_  
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	A	TITLE XVIII	B	TITLE XIX		
		1	2		3		4	
1	HOSPITAL	0		46,295		55,271	339,032	
100	TOTAL	0		46,295		55,271	339,032	

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET S-2  
 I I TO 12/31/2010 I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 5931 S HIGHWAY 94 P.O. BOX:  
 CITY: ST. CHARLES STATE: MO ZIP CODE: 63304-5601 COUNTY: ST CHARLES

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

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

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2010 TO: 12/31/2010

18 TYPE OF CONTROL 1 2  
4

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 4  
 20 SUBPROVIDER

OTHER INFORMATION

- 21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. 1
- 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. N 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). N N
- 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 1 N N 41180
- 21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 1
- 21.06 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 1
- 21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105 OR MIPPA §147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO. N
- 21.07 DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS). IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA SECTION 3121? 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. 3 N
- 22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N
- 23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N
- 23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. / / / /
- 23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY) / /
- 24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). / /

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011 I
I 26-4012 I FROM 1/ 1/2010 I WORKSHEET S-2
I I TO 12/31/2010 I

25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R? N
26 IF THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4? N
27 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.
28.03 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
28.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N
28.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)
28.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)
29 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.
26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /
26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /
27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. 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
28.02 ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY 0 0.0000 0.0000
0.00 0
A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR) % Y/N
28.03 STAFFING 0.00%
28.04 RECRUITMENT 0.00%
RETENTION 0.00%
TRAINING 0.00%
29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? N
30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) N
30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70
30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)
30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).
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
31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
31.01 IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
31.02 IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
31.03 IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
31.04 IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
31.05 IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
MISCELLANEOUS COST REPORT INFORMATION
32 IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2. N
33 IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2 N
34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA? N
35 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N
35.01 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N
35.02 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N
HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?
HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?

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

TITLE XIX INPATIENT SERVICES

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

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

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

41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? N  
 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
4 HOSPITAL	N	N	N	N	N	N	N

52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N

52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV N

53 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0

53.01 MDH PERIOD: BEGINNING: / / ENDING: / /  
 54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:  
 PREMIUMS: 74,500  
 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	FEEES 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).		N		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. N

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

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00

SETTLEMENT DATA

63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). Y 3/ 4/2011

HOSPITAL AND HOSPITAL HEALTH CARE  
COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
I 26-4012 I FROM 1/ 1/2010 I WORKSHEET S-3  
I I TO 12/31/2010 I PART I

COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH N/A	TITLE V	I/P DAYS / TITLE XVIII	O/P VISITS / NOT LTCH N/A	TRIPS TOTAL TITLE XIX
1 ADULTS & PEDIATRICS	1	84	2.01	3	4	6,369	5
2 HMO						513	
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS		84				6,369	4,263
10 RESIDENTIAL TREATMENT CENTER		12					
12 TOTAL		96				6,369	4,263
13 RPCH VISITS							
16 NURSING FACILITY							
25 TOTAL		96					
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	I/P DAYS / NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	/ TRIPS TOTAL OBSERVATION BEDS ADMITTED	NOT ADMITTED	INTERNS & RES. FTES TOTAL	RES. FTES LESS I&R REPL NON-PHYS ANES
1 ADULTS & PEDIATRICS	5.01	5.02	6	6.01	6.02	7	8
2 HMO			25,349				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS			25,349				
10 RESIDENTIAL TREATMENT CENTER			3,029				
12 TOTAL			28,378				
13 RPCH VISITS							
16 NURSING FACILITY							
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	--- FULL TIME EMPLOYEES ON PAYROLL	EQUIV NONPAID WORKERS	TITLE V	DISCHARGES TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2 HMO					486	288	2,820
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
10 RESIDENTIAL TREATMENT CENTER							
12 TOTAL		286.00			486	288	2,820
13 RPCH VISITS							
16 NURSING FACILITY							
25 TOTAL		286.00					
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 26-4012  
I

I PERIOD: I PREPARED 5/25/2011  
I FROM 1/ 1/2010 I WORKSHEET A  
I TO 12/31/2010 I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT				1,165,473	1,165,473
4	0400 NEW CAP REL COSTS-MVBLE EQUIP				755,989	755,989
5	0500 EMPLOYEE BENEFITS	152,874	3,025,680	3,178,554	-6,445	3,172,109
6	0600 ADMINISTRATIVE & GENERAL	3,113,317	4,232,802	7,346,119	-1,195,582	6,150,537
7	0700 MAINTENANCE & REPAIRS	194,657	368,563	563,220	-19,663	543,557
9	0900 LAUNDRY & LINEN SERVICE		49,371	49,371		49,371
10	1000 HOUSEKEEPING		240,891	240,891		240,891
11	1100 DIETARY	273,081	601,171	874,252		874,252
12	1200 CAFETERIA					
14	1400 NURSING ADMINISTRATION	731,510	30,027	761,537	-7,004	754,533
15	1500 CENTRAL SERVICES & SUPPLY					
16	1600 PHARMACY					
17	1700 MEDICAL RECORDS & LIBRARY	236,187	198,230	434,417	-51,471	382,946
18	1800 SOCIAL SERVICE	431,002	2,073	433,075	-49	433,026
19	0000 OTHER GENERAL SERVICE					
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	5,200,918	1,336,500	6,537,418	23,928	6,561,346
30	0000 RESIDENTIAL TREATMENT CENTER	497,507	182,961	680,468	11,078	691,546
35	3500 NURSING FACILITY					
	ANCILLARY SRVC COST CNTRS					
41	4100 RADIOLOGY-DIAGNOSTIC		34,650	34,650		34,650
44	4400 LABORATORY		103,786	103,786	-103,786	
54	5400 ELECTROENCEPHALOGRAPHY				76,025	76,025
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	5600 DRUGS CHARGED TO PATIENTS	12,989	635,980	648,969		648,969
59	0000 OTHER ANCILLARY					
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	3,523,033	1,395,445	4,918,478	-643,995	4,274,483
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		112,765	112,765	-112,765	
94	0000 OTHER SPECIAL PURPOSE					
95	SUBTOTALS	14,367,075	12,550,895	26,917,970	-108,267	26,809,703
	NONREIMBURS COST CENTERS					
97	9700 RESEARCH					
100	7950 OTHER NONREIMBURSABLE COST CENTERS				108,267	108,267
100.01	0000					
100.02	7952 OTHER NONREIMBURSABLE COST CENTERS					
	TOTAL	14,367,075	12,550,895	26,917,970	-0-	26,917,970

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
I 26-4012 I FROM 1/ 1/2010 I WORKSHEET A  
I I TO 12/31/2010 I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-1,164	1,164,309
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-5,998	749,991
5	0500 EMPLOYEE BENEFITS	-58,946	3,113,163
6	0600 ADMINISTRATIVE & GENERAL	-903,282	5,247,255
7	0700 MAINTENANCE & REPAIRS	-7,540	536,017
9	0900 LAUNDRY & LINEN SERVICE		49,371
10	1000 HOUSEKEEPING		240,891
11	1100 DIETARY	-34,747	839,505
12	1200 CAFETERIA		
14	1400 NURSING ADMINISTRATION		754,533
15	1500 CENTRAL SERVICES & SUPPLY		
16	1600 PHARMACY		
17	1700 MEDICAL RECORDS & LIBRARY	-1,361	381,585
18	1800 SOCIAL SERVICE		433,026
19	0000 OTHER GENERAL SERVICE		
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-845,424	5,715,922
30	0000 RESIDENTIAL TREATMENT CENTER	-142,700	548,846
35	3500 NURSING FACILITY		
	ANCILLARY SRVC COST CNTRS		
41	4100 RADIOLOGY-DIAGNOSTIC		34,650
44	4400 LABORATORY		
54	5400 ELECTROENCEPHALOGRAPHY		76,025
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		
56	5600 DRUGS CHARGED TO PATIENTS		648,969
59	0000 OTHER ANCILLARY		
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC	-717,868	3,556,615
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
94	0000 OTHER SPECIAL PURPOSE		
95	SUBTOTALS	-2,719,030	24,090,673
	NONREIMBURS COST CENTERS		
97	9700 RESEARCH		
100	7950 OTHER NONREIMBURSABLE COST CENTERS		108,267
100.01	0000		
100.02	7952 OTHER NONREIMBURSABLE COST CENTERS		
	TOTAL	-2,719,030	24,198,940

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
19	OTHER GENERAL SERVICE	0000	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
30	RESIDENTIAL TREATMENT CENTER	0000	
35	NURSING FACILITY	3500	
	ANCILLARY SRVC COST		
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
54	ELECTROENCEPHALOGRAPHY	5400	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
59	OTHER ANCILLARY	0000	
	OUTPAT SERVICE COST		
60	CLINIC	6000	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
94	OTHER SPECIAL PURPOSE	0000	
95	SUBTOTALS		
	NONREIMBURS COST CEN		OLD CAP REL COSTS-BLDG & FIXT
97	RESEARCH	9700	
100	OTHER NONREIMBURSABLE COST CENTERS	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01		0000	
100.02	OTHER NONREIMBURSABLE COST CENTERS	7952	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO: 264012	PERIOD: FROM 1/1/2010 TO 12/31/2010	PREPARED 5/25/2011 WORKSHEET A-6
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<PLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	INCREASE		
			LINE NO	SALARY OTHER	
	1	2	3	4	5
1 RECLASS SHORT AND LONG TERM LEASES	A	NEW CAP REL COSTS-BLDG & FIXT	3		1,073,020
2		NEW CAP REL COSTS-MVBLE EQUIP	4		201,831
3					
4					
5					
6					
7					
8 RECLASS LAB EXPENSE	B	ADULTS & PEDIATRICS	25		92,708
9		RESIDENTIAL TREATMENT CENTER	30		11,078
10 RECLASS COMMUNITY RELATIONS EXPENS	C	OTHER NONREIMBURSABLE COST CENTERS	100	62,900	45,367
11 RECLASS DEPRECIATION EXPENSE	D	NEW CAP REL COSTS-BLDG & FIXT	3		52,898
12		NEW CAP REL COSTS-MVBLE EQUIP	4		355,384
13 RECLASS PROPERTY TAX/INSURANCE	E	NEW CAP REL COSTS-BLDG & FIXT	3		16,119
14		NEW CAP REL COSTS-MVBLE EQUIP	4		80,996
15		NEW CAP REL COSTS-BLDG & FIXT	3		2,275
16		NEW CAP REL COSTS-MVBLE EQUIP	4		11,435
17		ADMINISTRATIVE & GENERAL	6		1,940
18 RECLASS LIGHT DUTY WAGES	F	ADULTS & PEDIATRICS	25	25,142	
19 RECLASS ECT COSTS	G	ELECTROENCEPHALOGRAPHY	54		76,025
20 RECLASS GENERAL LIABILITY & AUTO INS	H	NEW CAP REL COSTS-BLDG & FIXT	3		21,161
21		NEW CAP REL COSTS-MVBLE EQUIP	4		106,343
22		NEW CAP REL COSTS-MVBLE EQUIP	4		5,335
23 RECLASS ADMIN TIME TO A&G	I	ADMINISTRATIVE & GENERAL	6	89,200	
24 RECLASS ASSESSMENT SALARIES	J	ADMINISTRATIVE & GENERAL	6	71,800	
25 RECLASS TELEPHONE & POSTAGE EXPENSE	K	ADMINISTRATIVE & GENERAL	6		32,922
26					
27					
28					
29					
30					
36 TOTAL RECLASSIFICATIONS				249,042	2,186,837

(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 6	DECREASE		SALARY 8	OTHER 9	A-7 REF 10
			LINE NO 7				
1 RECLASS SHORT AND LONG TERM LEASES	A		5			6,377	10
2			6			722,249	10
3			7			18,041	10
4			14			6,961	10
5			17			50,711	10
6			25			17,897	10
7			60			452,615	10
8 RECLASS LAB EXPENSE	B		44			103,786	10
9							
10 RECLASS COMMUNITY RELATIONS EXPENS	C		6		62,900	45,367	9
11 RECLASS DEPRECIATION EXPENSE	D		6			52,898	9
12			6			355,384	9
13 RECLASS PROPERTY TAX/INSURANCE	E		88			16,119	11
14			88			80,996	11
15			88			13,710	11
16			88			1,940	11
17							
18 RECLASS LIGHT DUTY WAGES	F		6		25,142		
19 RECLASS ECT COSTS	G		25			76,025	
20 RECLASS GENERAL LIABILITY & AUTO INS	H		6			21,161	12
21			6			106,343	12
22			4			5,335	12
23 RECLASS ADMIN TIME TO A&G	I		60		89,200		
24 RECLASS ASSESSMENT SALARIES	J		60		71,800		
25 RECLASS TELEPHONE & POSTAGE EXPENSE	K		5			68	
26			7			1,622	
27			14			43	
28			17			760	
29			18			49	
30			60			30,380	
36 TOTAL RECLASSIFICATIONS					249,042	2,186,837	

(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

RECLASS CODE: A  
 EXPLANATION : RECLASS SHORT AND LONG TERM LEASES

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	1,073,020
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	201,831
3.00			0
4.00			0
5.00			0
6.00			0
7.00			0
TOTAL RECLASSIFICATIONS FOR CODE A			1,274,851

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
EMPLOYEE BENEFITS	5	6,377	
ADMINISTRATIVE & GENERAL	6	722,249	
MAINTENANCE & REPAIRS	7	18,041	
NURSING ADMINISTRATION	14	6,961	
MEDICAL RECORDS & LIBRARY	17	50,711	
ADULTS & PEDIATRICS	25	17,897	
CLINIC	60	452,615	
			1,274,851

RECLASS CODE: B  
 EXPLANATION : RECLASS LAB EXPENSE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ADULTS & PEDIATRICS	25	92,708
2.00	RESIDENTIAL TREATMENT CENTER	30	11,078
TOTAL RECLASSIFICATIONS FOR CODE B			103,786

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
LABORATORY	44	103,786	
		0	
			103,786

RECLASS CODE: C  
 EXPLANATION : RECLASS COMMUNITY RELATIONS EXPENS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	OTHER NONREIMBURSABLE COST CEN	100	108,267
TOTAL RECLASSIFICATIONS FOR CODE C			108,267

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	108,267	
			108,267

RECLASS CODE: D  
 EXPLANATION : RECLASS DEPRECIATION EXPENSE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	52,898
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	355,384
TOTAL RECLASSIFICATIONS FOR CODE D			408,282

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	52,898	
ADMINISTRATIVE & GENERAL	6	355,384	
			408,282

RECLASS CODE: E  
 EXPLANATION : RECLASS PROPERTY TAX/INSURANCE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	16,119
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	80,996
3.00	NEW CAP REL COSTS-BLDG & FIXT	3	2,275
4.00	NEW CAP REL COSTS-MVBLE EQUIP	4	11,435
5.00	ADMINISTRATIVE & GENERAL	6	1,940
TOTAL RECLASSIFICATIONS FOR CODE E			112,765

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
INTEREST EXPENSE	88	16,119	
INTEREST EXPENSE	88	80,996	
INTEREST EXPENSE	88	13,710	
INTEREST EXPENSE	88	1,940	
		0	
			112,765

RECLASS CODE: F  
 EXPLANATION : RECLASS LIGHT DUTY WAGES

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ADULTS & PEDIATRICS	25	25,142
TOTAL RECLASSIFICATIONS FOR CODE F			25,142

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	25,142	
			25,142

RECLASS CODE: G  
 EXPLANATION : RECLASS ECT COSTS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ELECTROENCEPHALOGRAPHY	54	76,025
TOTAL RECLASSIFICATIONS FOR CODE G			76,025

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADULTS & PEDIATRICS	25	76,025	
			76,025

RECLASS CODE: H  
 EXPLANATION : RECLASS GENERAL LIABILITY & AUTO INS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	21,161

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	21,161	

RECLASSIFICATIONS

IN LIEU OF FORM CMS-2552-96 (09/1996)  
 PROVIDER NO: 264012 | PERIOD: FROM 1/1/2010 TO 12/31/2010 | PREPARED 5/25/2011 WORKSHEET A-6 NOT A CMS WORKSHEET

RECLASS CODE: H  
 EXPLANATION : RECLASS GENERAL LIABILITY & AUTO INS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	106,343
3.00	NEW CAP REL COSTS-MVBLE EQUIP	4	5,335
TOTAL RECLASSIFICATIONS FOR CODE H			132,839

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	106,343	
NEW CAP REL COSTS-MVBLE EQUIP	4	5,335	
		132,839	

RECLASS CODE: I  
 EXPLANATION : RECLASS ADMIN TIME TO A&G

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	89,200
TOTAL RECLASSIFICATIONS FOR CODE I			89,200

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
CLINIC	60	89,200	
		89,200	

RECLASS CODE: J  
 EXPLANATION : RECLASS ASSESSMENT SALARIES

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	71,800
TOTAL RECLASSIFICATIONS FOR CODE J			71,800

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
CLINIC	60	71,800	
		71,800	

RECLASS CODE: K  
 EXPLANATION : RECLASS TELEPHONE & POSTAGE EXPENSE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	32,922
2.00			0
3.00			0
4.00			0
5.00			0
6.00			0
TOTAL RECLASSIFICATIONS FOR CODE K			32,922

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
EMPLOYEE BENEFITS	5	68	
MAINTENANCE & REPAIRS	7	1,622	
NURSING ADMINISTRATION	14	43	
MEDICAL RECORDS & LIBRARY	17	760	
SOCIAL SERVICE	18	49	
CLINIC	60	30,380	
		32,922	

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							
2 LAND IMPROVEMENTS							
3 BUILDINGS & FIXTURE							
4 BUILDING IMPROVEMEN	517,103	28,947		28,947		546,050	
5 FIXED EQUIPMENT							
6 MOVABLE EQUIPMENT	2,303,631	440,524		440,524		2,744,155	
7 SUBTOTAL	2,820,734	469,471		469,471		3,290,205	
8 RECONCILING ITEMS							
9 TOTAL	2,820,734	469,471		469,471		3,290,205	

III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL
		GROSS ASSETS 1	CAPITIALIZED GROSS ASSETS LEASES 2	FOR RATIO 3	RATIO 4	INSURANCE 5	TAXES 6	
3	NEW CAP REL COSTS-BL	517,103		517,103	.183322			
4	NEW CAP REL COSTS-MV	2,303,631		2,303,631	.816678			
5	TOTAL	2,820,734		2,820,734	1.000000			

DESCRIPTION SUMMARY OF OLD AND NEW CAPITAL

*	DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	51,734	1,073,020	18,394	21,161			1,164,309
4	NEW CAP REL COSTS-MV	349,386	201,831	92,431	106,343			749,991
5	TOTAL	401,120	1,274,851	110,825	127,504			1,914,300

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

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

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: I  
I 26-4012  
I

I PERIOD: I PREPARED 5/25/2011  
I FROM 1/ 1/2010 I WORKSHEET A-8  
I TO 12/31/2010 I

DESCRIPTION (1)	(2)	AMOUNT	EXPENSE CLASSIFICATION ON		WKST.	
	BASIS/CODE		WORKSHEET A TO/FROM WHICH THE	AMOUNT IS TO BE ADJUSTED		LINE NO
	1	2	COST CENTER	3	4	5
1			**COST CENTER DELETED**		1	
2			**COST CENTER DELETED**		2	
3			NEW CAP REL COSTS-BLDG &		3	
4			NEW CAP REL COSTS-MVBLE E		4	
5	B	-1,164	NEW CAP REL COSTS-BLDG &		3	9
6						
7						
8						
9						
10						
11						
12	A-8-2	-2,190,819				
13						
14	A-8-1					
15						
16	B	-34,747	DIETARY		11	
17						
18						
19						
20	B	-1,361	MEDICAL RECORDS & LIBRARY		17	
21						
22	B	-7,540	MAINTENANCE & REPAIRS		7	
23						
24						
25	A-8-3/A-8-4		**COST CENTER DELETED**		49	
26	A-8-3/A-8-4		**COST CENTER DELETED**		50	
27	A-8-3					
28			**COST CENTER DELETED**		89	
29			**COST CENTER DELETED**		1	
30			**COST CENTER DELETED**		2	
31			NEW CAP REL COSTS-BLDG &		3	
32			NEW CAP REL COSTS-MVBLE E		4	
33			**COST CENTER DELETED**		20	
34						
35	A-8-4		**COST CENTER DELETED**		51	
36	A-8-4		**COST CENTER DELETED**		52	
37	A	-8,024	ADMINISTRATIVE & GENERAL		6	
38	A	1,364,796	ADMINISTRATIVE & GENERAL		6	
39	B	-6,771	ADMINISTRATIVE & GENERAL		6	
40	B	-29,626	ADMINISTRATIVE & GENERAL		6	
41	A	-17,117	ADMINISTRATIVE & GENERAL		6	
42	A	-1,309	EMPLOYEE BENEFITS		5	
43	A	-410,379	ADMINISTRATIVE & GENERAL		6	
44	A	-5,998	NEW CAP REL COSTS-MVBLE E		4	9
45	A	-976,247	ADMINISTRATIVE & GENERAL		6	
46	A	-281,119	CLINIC		60	
47	A	-57,637	EMPLOYEE BENEFITS		5	
48	A	-53,968	CLINIC		60	9
49						
50		-2,719,030				

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 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 LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	6	819,914	819,914					
2	25	845,424	845,424					
3	30	142,700	142,700					
4	60	382,781	382,781					
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	2,190,819	2,190,819					

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET A-8-2  
 I I TO 12/31/2010 I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF COL 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COL 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
10	11	12	13	14	15	16	17	18
1	6	MEDICAL STAFF						819,914
2	25	PSYCH UNITS						845,424
3	30	RESIDENTIAL TREATMENT FAC						142,700
4	60	CLINIC						382,781
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL							2,190,819

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I NOT A CMS WORKSHEET  
 I I TO 12/31/2010 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS	SALARIESP	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	4	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	6	PATIENT DAYS		ENTERED
10	HOUSEKEEPING	4	SQUARE	FEET	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	7	PAID FTE'S		ENTERED
14	NURSING ADMINISTRATION	6	PATIENT DAYS		ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED	REQUIS.	NOT ENTERED
16	PHARMACY	11	PCT		ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME	SPENT	ENTERED
18	SOCIAL SERVICE	17	TIME	SPENT	ENTERED
19	OTHER GENERAL SERVICE				NOT ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET B  
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-MVBLE E 4	EMPLOYEE BENE FITS 5	SUBTOTAL 5a.00	ADMINISTRATIV E & GENERAL 6	MAINTENANCE & REPAIRS 7
003 GENERAL SERVICE COST CNTR					5a.00	6	7
004 NEW CAP REL COSTS-BLDG & 749,991	1,164,309	1,164,309					
005 NEW CAP REL COSTS-MVBLE E 749,991			749,991				
006 EMPLOYEE BENEFITS 3,113,163		13,843	8,917	3,135,923			
007 ADMINISTRATIVE & GENERAL 5,247,255		104,720	67,456	545,348	5,964,779	5,964,779	
009 MAINTENANCE & REPAIRS 536,017		48,363	31,153	46,612	662,145	216,602	878,747
010 LAUNDRY & LINEN SERVICE 49,371		11,205	7,217		67,793	22,177	13,490
011 HOUSEKEEPING 240,891		4,667	3,006		248,564	81,311	5,619
012 DIETARY 839,505		24,221	15,602	65,391	944,719	309,037	29,161
014 CAFETERIA 33,988		21,893			55,881	18,280	40,920
015 NURSING ADMINISTRATION 754,533		3,958	2,550	175,164	936,205	306,252	4,765
016 CENTRAL SERVICES & SUPPLY PHARMACY							
017 MEDICAL RECORDS & LIBRARY 381,585		21,109	13,598	56,556	472,848	154,679	25,415
018 SOCIAL SERVICE 433,026		24,890	16,033	103,206	577,155	188,800	29,967
019 OTHER GENERAL SERVICE							
025 INPAT ROUTINE SRVC CNTRS							
030 ADULTS & PEDIATRICS 5,715,922		467,421	301,090	1,251,407	7,735,840	2,530,556	562,765
035 RESIDENTIAL TREATMENT CEN 548,846		67,011	43,165	119,131	778,153	254,550	80,679
041 NURSING FACILITY							
044 ANCILLARY SRVC COST CNTRS							
054 RADIOLOGY-DIAGNOSTIC 34,650					34,650	11,335	
055 LABORATORY 76,025					76,025	24,869	
056 ELECTROENCEPHALOGRAPHY 648,969		5,238	3,374	3,110	660,691	216,126	6,306
059 MEDICAL SUPPLIES CHARGED TO PATIENTS							
060 OTHER ANCILLARY							
060 OUTPAT SERVICE COST CNTRS							
094 CLINIC 3,556,615		333,675	214,937	754,936	4,860,163	1,589,861	79,660
095 SPEC PURPOSE COST CENTERS							
097 OTHER SPECIAL PURPOSE							
100 SUBTOTALS 24,090,673		1,164,309	749,991	3,120,861	24,075,611	5,924,435	878,747
100 NONREIMBURS COST CENTERS							
100 RESEARCH							
100 01 OTHER NONREIMBURSABLE COS 108,267				15,062	123,329	40,344	
100 02 OTHER NONREIMBURSABLE COS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL 24,198,940		1,164,309	749,991	3,135,923	24,198,940	5,964,779	878,747

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET B  
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	CENTRAL SERVI CES & SUPPLY	PHARMACY
	9	10	11	12	14	15	16
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
009 MAINTENANCE & REPAIRS							
010 LAUNDRY & LINEN SERVICE	103,460						
011 HOUSEKEEPING		335,494					
012 DIETARY		11,381	1,294,298				
014 CAFETERIA		15,970	179,361	310,412			
015 NURSING ADMINISTRATION		1,860		22,959	1,272,041		
016 CENTRAL SERVICES & SUPPLY							
017 PHARMACY							
018 MEDICAL RECORDS & LIBRARY		9,919		14,993			
019 SOCIAL SERVICE		11,695					
025 OTHER GENERAL SERVICE							
030 INPAT ROUTINE SRVC CNTRS							
035 ADULTS & PEDIATRICS	92,417	219,632	991,291	248,096	1,136,266		
041 RESIDENTIAL TREATMENT CEN	11,043	31,487	123,646	24,364	135,775		
044 NURSING FACILITY							
054 ANCILLARY SRVC COST CNTRS							
055 RADIOLOGY-DIAGNOSTIC							
056 LABORATORY							
059 ELECTROENCEPHALOGRAPHY							
060 MEDICAL SUPPLIES CHARGED							
094 DRUGS CHARGED TO PATIENTS		2,461					
095 OTHER ANCILLARY							
099 OUTPAT SERVICE COST CNTRS							
100 CLINIC		31,089					
100 01 SPEC PURPOSE COST CENTERS							
100 02 OTHER SPECIAL PURPOSE							
100 SUBTOTALS	103,460	335,494	1,294,298	310,412	1,272,041		
100 01 NONREIMBURS COST CENTERS							
100 02 RESEARCH							
100 01 OTHER NONREIMBURSABLE COS							
100 02 OTHER NONREIMBURSABLE COS							
100 CROSS FOOT ADJUSTMENT							
100 NEGATIVE COST CENTER							
100 TOTAL	103,460	335,494	1,294,298	310,412	1,272,041		

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET B  
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	OTHER GENERAL SERVICE	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	17	18	19	25	26	27
003 GENERAL SERVICE COST CNTR						
004 NEW CAP REL COSTS-BLDG &						
005 NEW CAP REL COSTS-MVBLE E						
006 EMPLOYEE BENEFITS						
007 ADMINISTRATIVE & GENERAL						
009 MAINTENANCE & REPAIRS						
010 LAUNDRY & LINEN SERVICE						
011 HOUSEKEEPING						
012 DIETARY						
014 CAFETERIA						
015 NURSING ADMINISTRATION						
016 CENTRAL SERVICES & SUPPLY						
017 PHARMACY						
018 MEDICAL RECORDS & LIBRARY	677,854					
019 SOCIAL SERVICE		807,617				
025 OTHER GENERAL SERVICE						
030 INPAT ROUTINE SRVC CNTRS						
035 ADULTS & PEDIATRICS	616,230	717,882		14,850,975		14,850,975
041 RESIDENTIAL TREATMENT CEN	30,812	89,735		1,560,244		1,560,244
044 NURSING FACILITY						
054 ANCILLARY SRVC COST CNTRS						
055 RADIOLOGY-DIAGNOSTIC				45,985		45,985
056 LABORATORY						
059 ELECTROENCEPHALOGRAPHY				100,894		100,894
060 MEDICAL SUPPLIES CHARGED						
094 DRUGS CHARGED TO PATIENTS				885,584		885,584
095 OTHER ANCILLARY						
097 OUTPAT SERVICE COST CNTRS						
100 CLINIC	30,812			6,591,585		6,591,585
100.01 SPEC PURPOSE COST CENTERS						
100.02 OTHER SPECIAL PURPOSE						
100.02 SUBTOTALS	677,854	807,617		24,035,267		24,035,267
100.02 NONREIMBURS COST CENTERS						
100.02 RESEARCH						
100.02 OTHER NONREIMBURSABLE COS				163,673		163,673
100.02 CROSS FOOT ADJUSTMENT						
100.02 NEGATIVE COST CENTER						
100.02 TOTAL	677,854	807,617		24,198,940		24,198,940

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: 26-4012 I PERIOD: FROM 1/ 1/2010 TO 12/31/2010 I PREPARED 5/25/2011 I WORKSHEET B I PART III

COST CENTER DESCRIPTION	DIR ASSIGNED NEW CAPITAL REL COSTS 0	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-MVBLE E 4	SUBTOTAL 4a	EMPLOYEE BENE FITS 5	ADMINISTRATIV E & GENERAL 6	MAINTENANCE & REPAIRS 7
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG & NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS		13,843	8,917	22,760	22,760		
006 ADMINISTRATIVE & GENERAL		104,720	67,456	172,176	3,958	176,134	
007 MAINTENANCE & REPAIRS		48,363	31,153	79,516	338	6,396	86,250
009 LAUNDRY & LINEN SERVICE		11,205	7,217	18,422		655	1,324
010 HOUSEKEEPING		4,667	3,006	7,673		2,401	551
011 DIETARY		24,221	15,602	39,823	475	9,126	2,862
012 CAFETERIA		33,988	21,893	55,881		540	4,016
014 NURSING ADMINISTRATION		3,958	2,550	6,508	1,271	9,044	468
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY		21,109	13,598	34,707	410	4,568	2,495
018 SOCIAL SERVICE		24,890	16,033	40,923	749	5,575	2,941
019 OTHER GENERAL SERVICE							
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		467,421	301,090	768,511	9,083	74,721	55,236
030 RESIDENTIAL TREATMENT CEN		67,011	43,165	110,176	865	7,517	7,919
035 NURSING FACILITY							
041 ANCILLARY SRVC COST CNTRS RADIOLOGY-DIAGNOSTIC						335	
044 LABORATORY							
054 ELECTROENCEPHALOGRAPHY						734	
055 MEDICAL SUPPLIES CHARGED							
056 DRUGS CHARGED TO PATIENTS		5,238	3,374	8,612	23	6,382	619
059 OTHER ANCILLARY							
060 OUTPAT SERVICE COST CNTRS CLINIC		333,675	214,937	548,612	5,479	46,949	7,819
094 SPEC PURPOSE COST CENTERS							
095 OTHER SPECIAL PURPOSE							
095 SUBTOTALS		1,164,309	749,991	1,914,300	22,651	174,943	86,250
097 NONREIMBURS COST CENTERS RESEARCH							
100 OTHER NONREIMBURSABLE COS					109	1,191	
100 01 OTHER NONREIMBURSABLE COS							
100 02 OTHER NONREIMBURSABLE COS							
100 CROSS FOOT ADJUSTMENTS							
100 NEGATIVE COST CENTER							
100 TOTAL		1,164,309	749,991	1,914,300	22,760	176,134	86,250

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET B  
 I I TO 12/31/2010 I PART III

COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	CENTRAL SERVI CES & SUPPLY	PHARMACY
	9	10	11	12	14	15	16
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
009 MAINTENANCE & REPAIRS							
010 LAUNDRY & LINEN SERVICE	20,401						
011 HOUSEKEEPING		10,625					
012 DIETARY		360	52,646				
014 CAFETERIA		506	7,296	68,239			
015 NURSING ADMINISTRATION		59		5,047	22,397		
016 CENTRAL SERVICES & SUPPLY							
017 PHARMACY							
018 MEDICAL RECORDS & LIBRARY		314		3,296			
019 SOCIAL SERVICE		370					
025 OTHER GENERAL SERVICE							
030 INPAT ROUTINE SRVC CNTRS							
035 ADULTS & PEDIATRICS	18,223	6,956	40,321	54,540	20,006		
041 RESIDENTIAL TREATMENT CEN	2,178	997	5,029	5,356	2,391		
044 NURSING FACILITY							
054 ANCILLARY SRVC COST CNTRS							
055 RADIOLOGY-DIAGNOSTIC							
056 LABORATORY							
059 ELECTROENCEPHALOGRAPHY							
060 MEDICAL SUPPLIES CHARGED							
094 DRUGS CHARGED TO PATIENTS		78					
095 OTHER ANCILLARY							
097 OUTPAT SERVICE COST CNTRS							
100 CLINIC		985					
100 01 SPEC PURPOSE COST CENTERS							
100 02 OTHER SPECIAL PURPOSE							
100 02 SUBTOTALS	20,401	10,625	52,646	68,239	22,397		
100 02 NONREIMBURS COST CENTERS							
100 02 RESEARCH							
100 02 OTHER NONREIMBURSABLE COS							
100 02 CROSS FOOT ADJUSTMENTS							
100 02 NEGATIVE COST CENTER							
100 02 TOTAL	20,401	10,625	52,646	68,239	22,397		

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET 8  
 I I TO 12/31/2010 I PART III

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	OTHER GENERAL SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	17	18	19	25	26	27
003 GENERAL SERVICE COST CNTR						
004 NEW CAP REL COSTS-BLDG &						
005 NEW CAP REL COSTS-MVBLE E						
006 EMPLOYEE BENEFITS						
007 ADMINISTRATIVE & GENERAL						
009 MAINTENANCE & REPAIRS						
010 LAUNDRY & LINEN SERVICE						
011 HOUSEKEEPING						
012 DIETARY						
014 CAFETERIA						
015 NURSING ADMINISTRATION						
016 CENTRAL SERVICES & SUPPLY						
017 PHARMACY						
018 MEDICAL RECORDS & LIBRARY	45,790					
019 SOCIAL SERVICE		50,558				
025 OTHER GENERAL SERVICE						
030 INPAT ROUTINE SRVC CNTRS						
035 ADULTS & PEDIATRICS	41,628	44,940		1,134,165		1,134,165
041 RESIDENTIAL TREATMENT CEN	2,081	5,618		150,127		150,127
044 NURSING FACILITY						
054 ANCILLARY SRVC COST CNTRS						
055 RADIOLOGY-DIAGNOSTIC				335		335
056 LABORATORY						
059 ELECTROENCEPHALOGRAPHY				734		734
060 MEDICAL SUPPLIES CHARGED						
094 DRUGS CHARGED TO PATIENTS				15,714		15,714
095 OTHER ANCILLARY						
097 OUTPAT SERVICE COST CNTRS						
100 CLINIC	2,081			611,925		611,925
100 01 SPEC PURPOSE COST CENTERS						
100 02 OTHER SPECIAL PURPOSE						
095 SUBTOTALS	45,790	50,558		1,913,000		1,913,000
097 NONREIMBURS COST CENTERS						
100 RESEARCH						
100 01 OTHER NONREIMBURSABLE COS				1,300		1,300
100 02 OTHER NONREIMBURSABLE COS						
1 CROSS FOOT ADJUSTMENTS						
1 NEGATIVE COST CENTER						
003 TOTAL	45,790	50,558		1,914,300		1,914,300

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET B-1  
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS	
	OSTS-BLDG & (SQUARE FEET	OSTS-MVBLE E (SQUARE ) FEET	FITS (GROSS )ALARIESP			S RECONCIL- ) IATION
	3	4	5	6a.00	6	7
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	59,127					
005 NEW CAP REL COSTS-MVB		59,127				
006 EMPLOYEE BENEFITS	703	703	13,096,052			
007 ADMINISTRATIVE & GENE	5,318	5,318	2,277,446	-5,964,779	18,234,161	
009 MAINTENANCE & REPAIRS	2,456	2,456	194,657		662,145	37,065
010 LAUNDRY & LINEN SERVI	569	569			67,793	569
011 HOUSEKEEPING	237	237			248,564	237
012 DIETARY	1,230	1,230	273,081		944,719	1,230
014 CAFETERIA	1,726	1,726			55,881	1,726
015 NURSING ADMINISTRATIO	201	201	731,510		936,205	201
016 CENTRAL SERVICES & SU						
017 PHARMACY						
018 MEDICAL RECORDS & LIB	1,072	1,072	236,187		472,848	1,072
019 SOCIAL SERVICE	1,264	1,264	431,002		577,155	1,264
025 OTHER GENERAL SERVICE						
030 INPAT ROUTINE SRVC CN	23,737	23,737	5,226,059		7,735,840	23,737
035 ADULTS & PEDIATRICS	3,403	3,403	497,507		778,153	3,403
041 RESIDENTIAL TREATMENT						
044 NURSING FACILITY						
054 ANCILLARY SRVC COST C						
055 RADIOLOGY-DIAGNOSTIC					34,650	
056 LABORATORY					76,025	
059 ELECTROENCEPHALOGRAPH	266	266	12,989		660,691	266
060 MEDICAL SUPPLIES CHAR						
094 DRUGS CHARGED TO PATI						
095 OTHER ANCILLARY						
099 OUTPAT SERVICE COST C						
100 CLINIC	16,945	16,945	3,152,714		4,860,163	3,360
101 SPEC PURPOSE COST CEN						
102 OTHER SPECIAL PURPOSE						
103 SUBTOTALS	59,127	59,127	13,033,152	-5,964,779	18,110,832	37,065
104 NONREIMBURS COST CENT						
105 RESEARCH						
106 OTHER NONREIMBURSABLE			62,900		123,329	
107						
108						
109 01 OTHER NONREIMBURSABLE						
100 02 OTHER NONREIMBURSABLE						
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	1,164,309	749,991	3,135,923		5,964,779	878,747
104 (WRKSHT B, PART I)						
105 UNIT COST MULTIPLIER	19.691664		.239456		.327121	
106 (WRKSHT B, PT I)		12.684408				23.708269
107 COST TO BE ALLOCATED						
108 (WRKSHT B, PART II)						
109 UNIT COST MULTIPLIER						
110 (WRKSHT B, PT II)						
111 COST TO BE ALLOCATED			22,760		176,134	86,250
112 (WRKSHT B, PART III)						
113 UNIT COST MULTIPLIER			.001738		.009660	
114 (WRKSHT B, PT III)						2.326993

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET B-1  
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	CENTRAL SERVI CES & SUPPLY	PHARMACY
	(PATIENT DAYS )	(SQUARE FEET )	(MEALS )ERVED	S(PAID FTE'S )	(PATIENT DAYS )	(COSTED )EQUIS.	R(PCT )
	9	10	11	12	14	15	16
003 GENERAL SERVICE COST							
004 NEW CAP REL COSTS-BLD							
005 NEW CAP REL COSTS-MVB							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENE							
009 MAINTENANCE & REPAIRS							
010 LAUNDRY & LINEN SERVI	28,378						
011 HOUSEKEEPING		36,259					
012 DIETARY		1,230	96,848				
014 CAFETERIA		1,726	13,421	1,325			
015 NURSING ADMINISTRATIO		201		98	28,378		
016 CENTRAL SERVICES & SU							
017 PHARMACY							100
018 MEDICAL RECORDS & LIB		1,072		64			
019 SOCIAL SERVICE		1,264					
025 OTHER GENERAL SERVICE							
030 INPAT ROUTINE SRVC CN	25,349	23,737	74,175	1,059	25,349		
035 ADULTS & PEDIATRICS	3,029	3,403	9,252	104	3,029		
041 RESIDENTIAL TREATMENT							
044 NURSING FACILITY							
054 ANCILLARY SRVC COST C							
055 RADIOLOGY-DIAGNOSTIC							
056 LABORATORY							
059 ELECTROENCEPHALOGRAPH							
060 MEDICAL SUPPLIES CHAR		266					100
094 DRUGS CHARGED TO PATI							
095 OTHER ANCILLARY							
099 OUTPAT SERVICE COST C		3,360					
100 CLINIC							
101 SPEC PURPOSE COST CEN							
102 OTHER SPECIAL PURPOSE							
103 SUBTOTALS	28,378	36,259	96,848	1,325	28,378		100
104 NONREIMBURS COST CENT							
105 RESEARCH							
106 OTHER NONREIMBURSABLE							
107 01							
108 02 OTHER NONREIMBURSABLE							
109 CROSS FOOT ADJUSTMENT							
110 NEGATIVE COST CENTER							
111 COST TO BE ALLOCATED	103,460	335,494	1,294,298	310,412	1,272,041		
112 (WRKSHT B, PART I)							
113 UNIT COST MULTIPLIER		9.252710		234.273208			
114 (WRKSHT B, PT I)	3.645782		13.364220		44.824900		
115 COST TO BE ALLOCATED							
116 (WRKSHT B, PART II)							
117 UNIT COST MULTIPLIER							
118 (WRKSHT B, PT II)							
119 COST TO BE ALLOCATED	20,401	10,625	52,646	68,239	22,397		
120 (WRKSHT B, PART III)							
121 UNIT COST MULTIPLIER		.293031		51.501132			
122 (WRKSHT B, PT III)	.718902		.543594		.789238		

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET 8-1  
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY (TIME SPENT	SOCIAL SERVIC E (TIME )SPENT	OTHER GENERAL SERVICE )
	17	18	19
003 GENERAL SERVICE COST			
004 NEW CAP REL COSTS-BLD			
005 NEW CAP REL COSTS-MVB			
006 EMPLOYEE BENEFITS			
007 ADMINISTRATIVE & GENE			
009 MAINTENANCE & REPAIRS			
010 LAUNDRY & LINEN SERVI			
011 HOUSEKEEPING			
012 DIETARY			
014 CAFETERIA			
015 NURSING ADMINISTRATIO			
016 CENTRAL SERVICES & SU			
017 PHARMACY			
018 MEDICAL RECORDS & LIB	110		
019 SOCIAL SERVICE		9	
025 OTHER GENERAL SERVICE			
030 INPAT ROUTINE SRVC CN	100	8	
035 ADULTS & PEDIATRICS	5	1	
041 RESIDENTIAL TREATMENT			
044 NURSING FACILITY			
054 ANCILLARY SRVC COST C			
055 RADIOLOGY-DIAGNOSTIC			
056 LABORATORY			
059 ELECTROENCEPHALOGRAPH			
060 MEDICAL SUPPLIES CHAR			
094 DRUGS CHARGED TO PATI			
095 OTHER ANCILLARY			
099 OUTPAT SERVICE COST C			
100 CLINIC	5		
101 SPEC PURPOSE COST CEN			
102 OTHER SPECIAL PURPOSE			
103 SUBTOTALS	110	9	
104 NONREIMBURS COST CENT			
105 RESEARCH			
106 OTHER NONREIMBURSABLE			
107 01 OTHER NONREIMBURSABLE			
108 02 OTHER NONREIMBURSABLE			
109 CROSS FOOT ADJUSTMENT			
110 NEGATIVE COST CENTER			
111 COST TO BE ALLOCATED	677,854	807,617	
112 (PER WRKSHT B, PART			
113 UNIT COST MULTIPLIER		89,735.222222	
114 (WRKSHT B, PT I)	6,162.309091		
115 COST TO BE ALLOCATED			
116 (PER WRKSHT B, PART			
117 UNIT COST MULTIPLIER			
118 (WRKSHT B, PT II)			
119 COST TO BE ALLOCATED	45,790	50,558	
120 (PER WRKSHT B, PART			
121 UNIT COST MULTIPLIER		5,617.555556	
122 (WRKSHT B, PT III)	416.272727		

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET C  
 I I TO 12/31/2010 I PART I

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
29	INPAT ROUTINE SRVC CNTRS					
30	ADULTS & PEDIATRICS	14,850,975		14,850,975		14,850,975
35	RESIDENTIAL TREATMENT CEN NURSING FACILITY	1,560,244		1,560,244		1,560,244
41	ANCILLARY SRVC COST CNTRS					
44	RADIOLOGY-DIAGNOSTIC LABORATORY	45,985		45,985		45,985
54	ELECTROENCEPHALOGRAPHY	100,894		100,894		100,894
55	MEDICAL SUPPLIES CHARGED					
56	DRUGS CHARGED TO PATIENTS	885,584		885,584		885,584
59	OTHER ANCILLARY					
60	OUTPAT SERVICE COST CNTRS CLINIC	6,591,585		6,591,585		6,591,585
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	24,035,267		24,035,267		24,035,267
102	LESS OBSERVATION BEDS					
103	TOTAL	24,035,267		24,035,267		24,035,267

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	22,677,581		22,677,581			
30	RESIDENTIAL TREATMENT CEN	1,610,300		1,610,300			
35	NURSING FACILITY ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC	4,138		4,138	11.112856	11.112856	11.112856
44	LABORATORY						
54	ELECTROENCEPHALOGRAPHY	238,250		238,250	.423480	.423480	.423480
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS	1,314,443	54	1,314,497	.673706	.673706	.673706
59	OTHER ANCILLARY	160		160			
60	OUTPAT SERVICE COST CNTRS CLINIC		28,629,268	28,629,268	.230239	.230239	.230239
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	25,844,872	28,629,322	54,474,194			
102	LESS OBSERVATION BEDS						
103	TOTAL	25,844,872	28,629,322	54,474,194			

WKST A NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
41	ANCILLARY SRVC COST CNTRS						
44	RADIOLOGY-DIAGNOSTIC	45,985	335	45,650			45,985
54	LABORATORY						
55	ELECTROENCEPHALOGRAPHY	100,894	734	100,160			100,894
56	MEDICAL SUPPLIES CHARGED						
59	DRUGS CHARGED TO PATIENTS	885,584	15,714	869,870			885,584
	OTHER ANCILLARY						
60	OUTPAT SERVICE COST CNTRS						
	CLINIC	6,591,585	611,925	5,979,660			6,591,585
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	7,624,048	628,708	6,995,340			7,624,048
102	LESS OBSERVATION BEDS						
103	TOTAL	7,624,048	628,708	6,995,340			7,624,048

WKCT L	A NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	7	OUTPAT COST TO CHRG RATIO	8	I/P PT B COST TO CHRG RATIO	9
		ANCILLARY SRVC COST CNTRS						
41		RADIOLOGY-DIAGNOSTIC	4,138		11.112856		11.112856	
44		LABORATORY						
54		ELECTROENCEPHALOGRAPHY	238,250		.423480		.423480	
55		MEDICAL SUPPLIES CHARGED						
56		DRUGS CHARGED TO PATIENTS	1,314,497		.673706		.673706	
59		OTHER ANCILLARY	160					
60		OUTPAT SERVICE COST CNTRS CLINIC	28,629,268		.230239		.230239	
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	30,186,313					
102		LESS OBSERVATION BEDS						
103		TOTAL	30,186,313					

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET D  
 I I TO 12/31/2010 I PART I

TITLE XVIII, PART A

PPS

WI LI	NO.	COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
			CAPITAL REL COST (B, II) 1	SWING BED ADJUSTMENT 2	REDUCED CAP RELATED COST 3	CAPITAL REL COST (B, III) 4	SWING BED ADJUSTMENT 5	REDUCED CAP RELATED COST 6
25		INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS				1,134,165		1,134,165
30		RESIDENTIAL TREATMENT CEN				150,127		150,127
101		TOTAL				1,284,292		1,284,292

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET D  
 I I TO 12/31/2010 I PART I  
 PPS

TITLE XVIII, PART A

WKST A L 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	25,349	6,369			44.74	284,949
30	ADULTS & PEDIATRICS	3,029				49.56	
101	RESIDENTIAL TREATMENT CEN	28,378	6,369				284,949
	TOTAL						

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET D  
 I COMPONENT NO: I TO 12/31/2010 I PART II  
 I 26-4012 I I

TITLE XVIII, PART A

HOSPITAL

PPS

Wkst 1	A 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
		ANCILLARY SRVC COST CNTRS						
41		RADIOLOGY-DIAGNOSTIC		335	4,138	4,138		
44		LABORATORY						
54		ELECTROENCEPHALOGRAPHY		734	238,250	195,037		
55		MEDICAL SUPPLIES CHARGED						
56		DRUGS CHARGED TO PATIENTS		15,714	1,314,497	563,489		
59		OTHER ANCILLARY			160	160		
		OUTPAT SERVICE COST CNTRS						
60		CLINIC		611,925	28,629,268			
		OTHER REIMBURS COST CNTRS						
101		TOTAL		628,708	30,186,313	762,824		

APPORIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET D  
 I COMPONENT NO: I TO 12/31/2010 I PART II  
 I 26-4012 I I

TITLE XVIII, PART A HOSPITAL

WKST A NO.	COST CENTER DESCRIPTION	NEW CAPITAL CST/CHRG RATIO 7	COSTS 8
41	ANCILLARY SRVC COST CNTRS		
	RADIOLOGY-DIAGNOSTIC	.080957	335
44	LABORATORY		
54	ELECTROENCEPHALOGRAPHY	.003081	601
55	MEDICAL SUPPLIES CHARGED		
56	DRUGS CHARGED TO PATIENTS	.011954	6,736
59	OTHER ANCILLARY		
	OUTPAT SERVICE COST CNTRS		
60	CLINIC	.021374	
	OTHER REIMBURS COST CNTRS		
101	TOTAL		7,672

PPS

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

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
I 26-4012 I FROM 1/ 1/2010 I WORKSHEET D  
I I TO 12/31/2010 I PART III  
PPS

POST A NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	MED EDUCATN COST 2	SWING BED ADJ AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS					25,349	
30	RESIDENTIAL TREATMENT CEN					3,029	
35	NURSING FACILITY						
101	TOTAL					28,378	

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

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET D  
 I I TO 12/31/2010 I PART III

WKST A ( NO.	COST CENTER DESCRIPTION	INPATIENT PROG DAYS	INPAT PROGRAM PASS THRU COST
25	ADULTS & PEDIATRICS	7	8
30	RESIDENTIAL TREATMENT CEN		
35	NURSING FACILITY		
101	TOTAL	6,369	6,369

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET D  
 I COMPONENT NO: I TO 12/31/2010 I PART IV  
 I 26-4012 I

TITLE XVIII, PART A

HOSPITAL

PPS

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

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET D  
 I COMPONENT NO: I TO 12/31/2010 I PART IV  
 I 26-4012 I I

TITLE XVIII, PART A

HOSPITAL

PPS

W/CT NO.	A COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS							
41	RADIOLOGY-DIAGNOSTIC			4,138			4,138	
44	LABORATORY							
54	ELECTROENCEPHALOGRAPHY			238,250			195,037	
55	MEDICAL SUPPLIES CHARGED							
56	DRUGS CHARGED TO PATIENTS			1,314,497			563,489	
59	OTHER ANCILLARY			160			160	
	OUTPAT SERVICE COST CNTRS							
60	CLINIC			28,629,268				
	OTHER REIMBURS COST CNTRS							
101	TOTAL			30,186,313			762,824	

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A NO.	COST CENTER DESCRIPTION	OUTPUT PROG CHARGES	OUTPUT PROG D,V COL 5.03	OUTPUT PROG D,V COL 5.04	OUTPUT PROG PASS THRU COST	COL 8.01 * COL 5	COL 8.02 * COL 5
	ANCILLARY SRVC COST CNTRS	8	8.01	8.02	9	9.01	9.02
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
59	OTHER ANCILLARY						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	16,801,701					
	OTHER REIMBURS COST CNTRS						
101	TOTAL	16,801,701					

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET D-1  
 I COMPONENT NO: I TO 12/31/2010 I PART I  
 I 26-4012 I I

TITLE XVIII PART A HOSPITAL PPS

Part I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	25,349
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	25,349
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	25,349
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)	6,369
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 XVII 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	
	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	14,850,975
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	14,850,975

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	14,850,975

TITLE XVIII PART A HOSPITAL PPS

II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE  
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 585.86  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 3,731,342  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 3,731,342

	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 RESIDENTIAL TREATMENT CENTER	1,560,244	3,029	515.10		
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1 508,205
49 TOTAL PROGRAM INPATIENT COSTS					4,239,547

PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES 284,949  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES 7,672  
 52 TOTAL PROGRAM EXCLUDABLE COST 292,621  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN  
 ANESTHETIST, AND MEDICAL EDUCATION COSTS 3,946,926

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET D-1  
 I COMPONENT NO: I TO 12/31/2010 I PART III  
 I 26-4012 I I

TITLE XVIII PART A HOSPITAL PPS

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

1

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

PART IV - COMPUTATION OF OBSERVATION BED COST

- 83 TOTAL OBSERVATION BED DAYS
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 585.86
- 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		14,850,975			
87 NEW CAPITAL-RELATED COST	1,134,165	14,850,975	.076370		
NON PHYSICIAN ANESTHETIST		14,850,975			
MEDICAL EDUCATION		14,850,975			
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  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET D-4  
 I COMPONENT NO: I TO 12/31/2010 I  
 I 26-4012 I PPS I

TITLE XVIII, PART A HOSPITAL

Wkst A NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		5,767,916	
30	RESIDENTIAL TREATMENT CENTER			
	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC	11.112856	4,138	45,985
44	LABORATORY			
54	ELECTROENCEPHALOGRAPHY	.423480	195,037	82,594
55	MEDICAL SUPPLIES CHARGED TO PATIENTS			
56	DRUGS CHARGED TO PATIENTS	.673706	563,489	379,626
59	OTHER ANCILLARY		160	
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.230239		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		762,824	508,205
102	LESS PBP CLINIC LABORATORY SERVICES -			
	PROGRAM ONLY CHARGES			
103	NET CHARGES		762,824	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	3,868,407
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	4,916,063
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	

COMPUTATION OF LESSER OF COST OR CHARGES

REASONABLE CHARGES		
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	4,916,063

COMPUTATION OF REIMBURSEMENT SETTLEMENT

DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		
17.01	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 17.01 (SEE INSTRUCTIONS)	1,012,094
19	SUBTOTAL (SEE INSTRUCTIONS)	3,903,969
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	3,903,969
24	PRIMARY PAYER PAYMENTS	
25	SUBTOTAL	3,903,969

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	177,655
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	124,359
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	55,065
28	SUBTOTAL	4,028,328
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	358
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	11,493
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	4,017,193
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	3,961,922
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	55,271
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)	
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)	
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY	
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	
54	TOTAL (SUM OF LINES 51 AND 53)	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET E-1  
 I COMPONENT NO: I TO 12/31/2010 I  
 I 26-4012 I I

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	12/31/2010	91,200	12/31/2010	64,400
	ADJUSTMENTS TO PROVIDER	.02				
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50				
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL	.99		91,200		64,400
4	TOTAL INTERIM PAYMENTS			3,691,442		3,961,922
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			46,295		55,271
	SETTLEMENT TO PROVIDER	.01				
	SETTLEMENT TO PROGRAM	.02				
7	TOTAL MEDICARE PROGRAM LIABILITY			3,737,737		4,017,193

NAME OF INTERMEDIARY:  
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I WORKSHEET E-3  
 I COMPONENT NO: I TO 12/31/2010 I PART I  
 I 26-4012 I I

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

1	INPATIENT HOSPITAL SERVICES (SEE INSTRUCTIONS)	
1.01	HOSPITAL SPECIFIC AMOUNT (SEE INSTRUCTIONS)	
1.02	ENTER FROM THE PS&R, THE IRF PPS PAYMENT	
1.03	MEDICARE SSI RATIO (IRF PPS ONLY) (SEE INSTR.)	
1.04	INPATIENT REHABILITATION FACILITY LIP PAYMENTS (SEE INSTRUCTIONS)	
1.05	OUTLIER PAYMENTS	
1.06	TOTAL PPS PAYMENTS (SUM OF LINES 1.01, (1.02, 1.04 FOR COLUMNS 1 & 1.01), 1.05 AND 1.42)	
1.07	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)	
	INPATIENT PSYCHIATRIC FACILITY (IPF)	
1.08	NET FEDERAL IPF PPS PAYMENTS (EXCLUDING OUTLIER, ECT, STOP-LOSS, AND MEDICAL EDUCATION PAYMENTS)	4,122,818
1.09	NET IPF PPS OUTLIER PAYMENTS	25,673
1.10	NET IPF PPS ECT PAYMENTS	13,057
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)	69.449315
1.17	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{(1 + (LINE 1.15/1.16))\}$ RAISED TO THE POWER OF .5150 - 1.	
1.18	MEDICAL EDUCATION ADJUSTMENT (LINE 1.08 MULTIPLIED BY LINE 1.17).	
1.19	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1.08, 1.09, 1.10 AND 1.18)	4,161,548
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)	4,161,548
	INPATIENT REHABILITATION FACILITY (IRF)	
1.35	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR COST REPORT PERIODS ENDING ON/OR PRIOR TO NOVEMBER 15, 2004. (SEE INST.)	
1.36	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)	
1.37	CURRENT YEAR'S UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.38	CURRENT YEAR'S UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.39	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.40	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	
1.41	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{(1 + (LINE 1.39/1.40))\}$ RAISED TO THE POWER OF .9012 - 1.	
1.42	MEDICAL EDUCATION ADJUSTMENT (LINE 1.02 MULTIPLIED BY LINE 1.41).	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL (SEE INSTRUCTIONS)	4,161,548
5	PRIMARY PAYER PAYMENTS	60,382
6	SUBTOTAL	4,101,166
7	DEDUCTIBLES	318,086
8	SUBTOTAL	3,783,080
9	COINSURANCE	189,451
10	SUBTOTAL	3,593,629
11	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROF SERVS)	205,868
11.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	144,108
11.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	102,344
	SUBTOTAL	3,737,737
J	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED
I	26-4012	I	FROM 1/ 1/2010	I	5/25/2011
I	COMPONENT NO:	I	TO 12/31/2010	I	WORKSHEET E-3
I	26-4012	I		I	PART I

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

13.01	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)	
14	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
15	OTHER ADJUSTMENTS (SPECIFY)	
15.99	OUTLIER RECONCILIATION ADJUSTMENT	
16	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
17	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	3,737,737
18	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
19	INTERIM PAYMENTS	3,691,442
19.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
20	BALANCE DUE PROVIDER/PROGRAM	46,295
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

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

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

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS				
2	TEMPORARY INVESTMENTS	324,335			
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE				
5	OTHER RECEIVABLES	7,706,298			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	51,984			
		-1,884,981			
7	INVENTORY	169,850			
8	PREPAID EXPENSES	117,562			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	6,485,048			
FIXED ASSETS					
12	LAND				
12.01	LAND IMPROVEMENTS				
13	LAND IMPROVEMENTS				
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS				
14.01	LESS ACCUMULATED DEPRECIATION				
15	LEASEHOLD IMPROVEMENTS	546,051			
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	2,744,156			
18.01	LESS ACCUMULATED DEPRECIATION	-1,820,389			
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	1,469,818			
OTHER ASSETS					
22	INVESTMENTS	200,000			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS	36,756			
25	OTHER ASSETS				
26	TOTAL OTHER ASSETS	236,756			
7	TOTAL ASSETS	8,191,622			

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 I FROM 1/ 1/2010 I  
 I I TO 12/31/2010 I WORKSHEET G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
28 CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	563,948			
29 SALARIES, WAGES & FEES PAYABLE	541,799			
30 PAYROLL TAXES PAYABLE	23,812			
31 NOTES AND LOANS PAYABLE (SHORT TERM)				
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	635,161			
36 TOTAL CURRENT LIABILITIES	1,764,720			
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	-188,557			
42 TOTAL LONG-TERM LIABILITIES	-188,557			
43 TOTAL LIABILITIES	1,576,163			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	6,615,459			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	6,615,459			
52 TOTAL LIABILITIES AND FUND BALANCES	8,191,622			

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/25/2011  
 I 26-4012 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	22,152,555		22,152,555
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
7 00 NURSING FACILITY			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	22,152,555		22,152,555
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
14 00 RESIDENTIAL TREATMENT CENTER	1,610,300		1,610,300
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	1,610,300		1,610,300
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	23,762,855		23,762,855
17 00 ANCILLARY SERVICES	2,056,054		2,056,054
18 00 OUTPATIENT SERVICES		29,376,923	29,376,923
24 00			
25 00 TOTAL PATIENT REVENUES	25,818,909	29,376,923	55,195,832

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		26,917,970	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		26,917,970	

## STATEMENT OF REVENUES AND EXPENSES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/25/2011
I	26-4012	I	FROM 1/ 1/2010	I	WORKSHEET G-3
I		I	TO 12/31/2010	I	

## DESCRIPTION

1	TOTAL PATIENT REVENUES	55,195,832
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	26,107,282
3	NET PATIENT REVENUES	29,088,550
4	LESS: TOTAL OPERATING EXPENSES	26,917,970
5	NET INCOME FROM SERVICE TO PATIENTS	2,170,580
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	21,515
7	INCOME FROM INVESTMENTS	1,164
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	34,747
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)	1,361
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	7,540
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	MISC	14,882
25	TOTAL OTHER INCOME	81,209
26	TOTAL	2,251,789
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	2,251,789

COMPUTATION OF RATIO OF COSTS TO CHARGES  
 SPECIAL TITLE XIX WORKSHEET

WKST A LJNF 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	14,850,975		14,850,975		14,850,975
30	RESIDENTIAL TREATMENT CEN	1,560,244		1,560,244		1,560,244
35	NURSING FACILITY					
41	ANCILLARY SRVC COST CNTRS					
44	RADIOLOGY-DIAGNOSTIC LABORATORY	45,985		45,985		45,985
54	ELECTROENCEPHALOGRAPHY	100,894		100,894		100,894
55	MEDICAL SUPPLIES CHARGED					
56	DRUGS CHARGED TO PATIENTS	885,584		885,584		885,584
59	OTHER ANCILLARY					
60	OUTPAT SERVICE COST CNTRS CLINIC	6,591,585		6,591,585		6,591,585
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	24,035,267		24,035,267		24,035,267
102	LESS OBSERVATION BEDS					
103	TOTAL	24,035,267		24,035,267		24,035,267

COMPUTATION OF RATIO OF COSTS TO CHARGES  
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	22,677,581		22,677,581			
30	RESIDENTIAL TREATMENT CEN	1,610,300		1,610,300			
35	NURSING FACILITY						
41	ANCILLARY SRVC COST CNTRS						
44	RADIOLOGY-DIAGNOSTIC	4,138		4,138	11.112856	11.112856	11.112856
54	LABORATORY						
55	ELECTROENCEPHALOGRAPHY	238,250		238,250	.423480	.423480	.423480
56	MEDICAL SUPPLIES CHARGED						
59	DRUGS CHARGED TO PATIENTS	1,314,443	54	1,314,497	.673706	.673706	.673706
	OTHER ANCILLARY	160		160			
60	OUTPAT SERVICE COST CNTRS						
	CLINIC		28,629,268	28,629,268	.230239	.230239	.230239
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	25,844,872	28,629,322	54,474,194			
102	LESS OBSERVATION BEDS						
103	TOTAL	25,844,872	28,629,322	54,474,194			

WKST A NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
41	ANCILLARY SRVC COST CNTRS						
	RADIOLOGY-DIAGNOSTIC	45,985	335	45,650			45,985
44	LABORATORY						
54	ELECTROENCEPHALOGRAPHY	100,894	734	100,160			100,894
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS	885,584	15,714	869,870			885,584
59	OTHER ANCILLARY						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	6,591,585	611,925	5,979,660			6,591,585
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	7,624,048	628,708	6,995,340			7,624,048
102	LESS OBSERVATION BEDS						
103	TOTAL	7,624,048	628,708	6,995,340			7,624,048

\*\*NOT A CMS WORKSHEET \*\*

(09/2000)

WKST A E NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
41	ANCILLARY SRVC COST CNTRS			
44	RADIOLOGY-DIAGNOSTIC	4,138	11.112856	11.112856
54	LABORATORY			
55	ELECTROENCEPHALOGRAPHY	238,250	.423480	.423480
56	MEDICAL SUPPLIES CHARGED			
59	DRUGS CHARGED TO PATIENTS	1,314,497	.673706	.673706
	OTHER ANCILLARY	160		
60	OUTPAT SERVICE COST CNTRS			
	CLINIC	28,629,268	.230239	.230239
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	30,186,313		
102	LESS OBSERVATION BEDS			
103	TOTAL	30,186,313		