Ranken Jordan

Title XVIII Medicare Cost Report

Provider No. 26-3303

June 30, 2010

BKD LLP
CPAs & Advisors

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 COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 26-3303	PERIOD FROM 7/ 1/2009 TO 6/30/2010	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 11/23/2010 TIME 8:03

PART I - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
RANKEN JORDAN 26-3303
FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2009 AND ENDING 6/30/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
DATE: 11/23/2010 TIME 8:03

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UXNx0pTkKO0eA:8Y

PI ENCRYPTION INFORMATION
DATE: 11/23/2010 TIME 8:03

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pk4i2I9age0wSD2i

_____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			A	B		
		1	2	3	4	
1	HOSPITAL	0	37,883	0	2,173,915	
100	TOTAL	0	37,883	0	2,173,915	

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | PROVIDER NO: 26-3303 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 11365 DORSETT ROAD P.O. BOX:

1.01 CITY: MARYLAND HEIGHTS STATE: MO ZIP CODE: 63043- COUNTY: SAINT LOUIS

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

	COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX
	0	1	2	2.01	3	4	5	6
02.00	HOSPITAL	RANKEN JORDAN	26-3303		7/31/2002	N	T	O

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 7/ 1/2009 TO: 6/30/2010

		1	2
18	TYPE OF CONTROL	2	

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	7
20	SUBPROVIDER	

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.				
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.	N			
21.02	HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).				
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	1	N		Y 7040
21.04	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	1			
21.05	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	1			
21.06	DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105 OR MIPPA §147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO.	Y			
21.07	DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS). 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.				
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	N			
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW.	N			
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.			/ /	/ /
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.			/ /	/ /
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.			/ /	/ /
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.			/ /	/ /
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.			/ /	/ /
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.			/ /	/ /
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.			/ /	/ /
24	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY)				/ /
24.01	IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy).				/ /

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R?	N
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	N
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)	
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH),ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /	
26.02	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /	
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	N / /

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

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

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

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

MISCELLANEOUS COST REPORT INFORMATION

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

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

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

40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS).	Y	
40.01	NAME: FI/CONTRACTOR NAME		FI/CONTRACTOR #
40.02	STREET: P.O. BOX:		
40.03	CITY: STATE: ZIP CODE: -		
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY?	N	
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.	N	00/00/0000
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?		
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?		
45.03	WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?		
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).		

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

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

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS)	N	
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV	N	
53	IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0	
53.01	MDH PERIOD: BEGINNING: / / ENDING: / /		
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:		
	PREMIUMS:	185,373	
	PAID LOSSES:	0	
	AND/OR SELF INSURANCE:	0	
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N	
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.	N	

		DATE 0	Y OR N 1	LIMIT 2	Y OR N 3	FEES 4
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		N	0.00		0
56.01	ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02	THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03	FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0

57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?	N	
58	ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.	N	
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y"FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).	N	0
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)	N	
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)	N	
60.01	IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(C)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC).		0

MULTICAMPUS

61.00 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA? ENTER "Y" FOR YES AND "N" FOR NO. 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 9/30/2010

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

I PROVIDER NO: 26-3303 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET S-3 I PART I

	COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH	I/P DAYS / TITLE V	I/P DAYS / TITLE XVIII	O/P VISITS / NOT LTCH	TRIPS / TOTAL TITLE XIX
		1	2	2.01	3	4	4.01	5
1	ADULTS & PEDIATRICS	34	12,410			30		4,840
2	HMO							4,122
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	34	12,410			30		4,840
12	TOTAL	34	12,410			30		4,840
13	RPCH VISITS							
25	TOTAL	34						
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I/P DAYS / TITLE XIX ADMITTED	I/P DAYS / OBSERVATION BEDS NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	TRIPS / TOTAL OBSERVATION BEDS ADMITTED	TRIPS / OBSERVATION BEDS NOT ADMITTED	-- INTERNS & RES. FTES -- TOTAL	LESS I&R REPL NON-PHYS ANES
		5.01	5.02	6	6.01	6.02	7	8
1	ADULTS & PEDIATRICS			10,599				
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS			10,599				
12	TOTAL			10,599				
13	RPCH VISITS							
25	TOTAL							
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I & R FTES NET	FULL TIME EQUIV EMPLOYEES ON PAYROLL	FULL TIME EQUIV NONPAID WORKERS	DISCHARGES TITLE V	DISCHARGES TITLE XVIII	DISCHARGES TITLE XIX	TOTAL ALL PATIENTS
		9	10	11	12	13	14	15
1	ADULTS & PEDIATRICS					2	75	224
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
12	TOTAL		209.67			2	75	224
13	RPCH VISITS							
25	TOTAL		209.67					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

HOSPITAL UNCOMPENSATED CARE DATA

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
26-3303	FROM 7/ 1/2009	WORKSHEET S-10
	TO 6/30/2010	

	DESCRIPTION	
	UNCOMPENSATED CARE INFORMATION	
1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	
2.01	IS IT AT THE TIME OF ADMISSION?	
2.02	IS IT AT THE TIME OF FIRST BILLING?	
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	
2.04		
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	
4	ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	
5	ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?	
6	ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?	
7	ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?	
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?	
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04	
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	
14	IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02	
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?	
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	
	UNCOMPENSATED CARE REVENUES	
17	REVENUE FROM UNCOMPENSATED CARE	
17.01	GROSS MEDICAID REVENUES	
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	
20	RESTRICTED GRANTS	
21	NON-RESTRICTED GRANTS	
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	
	UNCOMPENSATED CARE COST	
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103)	.678530
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)	
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	
27	TOTAL SCHIP COST, (LINE 24 * LINE 26)	
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	25,218,950

HOSPITAL UNCOMPENSATED CARE DATA

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
26-3303	FROM 7/ 1/2009	WORKSHEET S-10
	TO 6/30/2010	

	DESCRIPTION	
29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	17,111,814
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	169,499
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	115,010
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29)	17,111,814

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 26-3303 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		896,643	896,643	669,785	1,566,428
4	0400	NEW CAP REL COSTS-MVBLE EQUIP				395,828	395,828
5	0500	EMPLOYEE BENEFITS	354,257	2,628,822	2,983,079		2,983,079
6	0600	ADMINISTRATIVE & GENERAL	1,920,637	2,767,012	4,687,649	90,730	4,778,379
7	0700	MAINTENANCE & REPAIRS	369,215	519,557	888,772		888,772
11	1100	DIETARY	204,263	68,805	273,068		273,068
14	1400	NURSING ADMINISTRATION	391,325	7,298	398,623	517,388	916,011
18	1800	SOCIAL SERVICE	127,112	89,189	216,301		216,301
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	5,624,639	970,385	6,595,024	-943,863	5,651,161
		ANCILLARY SRVC COST CNTRS					
41	4100	RADIOLOGY-DIAGNOSTIC		55,121	55,121		55,121
44	4400	LABORATORY		58,661	58,661		58,661
49	4900	RESPIRATORY THERAPY	809,225	478,683	1,287,908		1,287,908
50	5000	PHYSICAL THERAPY	1,913,266	122,463	2,035,729	-111,453	1,924,276
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	179,286	1,153	180,439	380,012	560,451
56	5600	DRUGS CHARGED TO PATIENTS	322,626	760,799	1,083,425		1,083,425
		OUTPAT SERVICE COST CNTRS					
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
		OTHER REIMBURS COST CNTRS					
68	5950	OTHER REIMBURSABLE COST CENTERS		91,506	91,506		91,506
		SPEC PURPOSE COST CENTERS					
88	8800	INTEREST EXPENSE		998,427	998,427	-998,427	
90	9000	OTHER CAPITAL RELATED COSTS					
95		SUBTOTALS	12,215,851	10,514,524	22,730,375	-0-	22,730,375
		NONREIMBURS COST CENTERS					
100	7950	RESPITE					
101		TOTAL	12,215,851	10,514,524	22,730,375	-0-	22,730,375

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | I PROVIDER NO: 26-3303 | I PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | I PREPARED 11/23/2010 WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
			6	7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT	354,310	1,920,738
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		395,828
5	0500	EMPLOYEE BENEFITS	-240,511	2,742,568
6	0600	ADMINISTRATIVE & GENERAL	-575,241	4,203,138
7	0700	MAINTENANCE & REPAIRS		888,772
11	1100	DIETARY		273,068
14	1400	NURSING ADMINISTRATION		916,011
18	1800	SOCIAL SERVICE		216,301
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS	-1,527,760	4,123,401
		ANCILLARY SRVC COST CNTRS		
41	4100	RADIOLOGY-DIAGNOSTIC		55,121
44	4400	LABORATORY		58,661
49	4900	RESPIRATORY THERAPY		1,287,908
50	5000	PHYSICAL THERAPY		1,924,276
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		560,451
56	5600	DRUGS CHARGED TO PATIENTS		1,083,425
		OUTPAT SERVICE COST CNTRS		
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
		OTHER REIMBURS COST CNTRS		
68	5950	OTHER REIMBURSABLE COST CENTERS		91,506
		SPEC PURPOSE COST CENTERS		
88	8800	INTEREST EXPENSE		-0-
90	9000	OTHER CAPITAL RELATED COSTS		-0-
95		SUBTOTALS	-1,989,202	20,741,173
		NONREIMBURS COST CENTERS		
100	7950	RESPITE		
101		TOTAL	-1,989,202	20,741,173

COST CENTERS USED IN COST REPORT

I PROVIDER NO:	I PERIOD:	I PREPARED 11/23/2010
I 26-3303	I FROM 7/ 1/2009	I NOT A CMS WORKSHEET
I	I TO 6/30/2010	I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
11	DIETARY	1100	
14	NURSING ADMINISTRATION	1400	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
	ANCILLARY SRVC COST		
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	OTHER REIMBURS COST		
68	OTHER REIMBURSABLE COST CENTERS	5950	OTHER REIMBURSABLE COST CENTERS
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
100	RESPITE	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	INCREASE SALARY	INCREASE OTHER
		1	2	3	4	5
1	INTEREST EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		998,427
2	NURSING ADMIN AND SUPERVISOR	B	NURSING ADMINISTRATION	14	517,388	
3	MEDICAL SUPPLY EXPENSE	C	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		380,012
4	DEPRECIATION EXPENSE	D	NEW CAP REL COSTS-MVBLE EQUIP	4		386,188
5	INSURANCE EXPENSE	E	OTHER CAPITAL RELATED COSTS	90		60,406
6	PROPERTY TAXES	F	OTHER CAPITAL RELATED COSTS	90		6,780
7	FRONT DESK AND SECURITY SALARY EXPEN	G	ADMINISTRATIVE & GENERAL	6	157,916	
8	PT NURSING SALARY EXPENSE	H	PHYSICAL THERAPY	50	46,463	
36	TOTAL RECLASSIFICATIONS				721,767	1,831,813

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

RECLASSIFICATIONS | PROVIDER NO: 263303 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	DECREASE SALARY	DECREASE OTHER	A-7 REF
		1	6	7	8	9	10
1	INTEREST EXPENSE	A	INTEREST EXPENSE	88		998,427	11
2	NURSING ADMIN AND SUPERVISOR	B	ADULTS & PEDIATRICS	25	517,388		
3	MEDICAL SUPPLY EXPENSE	C	ADULTS & PEDIATRICS	25		380,012	
4	DEPRECIATION EXPENSE	D	NEW CAP REL COSTS-BLDG & FIXT	3		386,188	9
5	INSURANCE EXPENSE	E	ADMINISTRATIVE & GENERAL	6		60,406	
6	PROPERTY TAXES	F	ADMINISTRATIVE & GENERAL	6		6,780	
7	FRONT DESK AND SECURITY SALARY EXPEN	G	PHYSICAL THERAPY	50	157,916		
8	PT NURSING SALARY EXPENSE	H	ADULTS & PEDIATRICS	25	46,463		
36	TOTAL RECLASSIFICATIONS				721,767	1,831,813	

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

RECLASS CODE: A
EXPLANATION : INTEREST EXPENSE

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	998,427	INTEREST EXPENSE	88	998,427
TOTAL RECLASSIFICATIONS FOR CODE A			998,427			998,427

RECLASS CODE: B
EXPLANATION : NURSING ADMIN AND SUPERVISOR

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NURSING ADMINISTRATION	14	517,388	ADULTS & PEDIATRICS	25	517,388
TOTAL RECLASSIFICATIONS FOR CODE B			517,388			517,388

RECLASS CODE: C
EXPLANATION : MEDICAL SUPPLY EXPENSE

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	380,012	ADULTS & PEDIATRICS	25	380,012
TOTAL RECLASSIFICATIONS FOR CODE C			380,012			380,012

RECLASS CODE: D
EXPLANATION : DEPRECIATION EXPENSE

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	386,188	NEW CAP REL COSTS-BLDG & FIXT	3	386,188
TOTAL RECLASSIFICATIONS FOR CODE D			386,188			386,188

RECLASS CODE: E
EXPLANATION : INSURANCE EXPENSE

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OTHER CAPITAL RELATED COSTS	90	60,406	ADMINISTRATIVE & GENERAL	6	60,406
TOTAL RECLASSIFICATIONS FOR CODE E			60,406			60,406

RECLASS CODE: F
EXPLANATION : PROPERTY TAXES

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OTHER CAPITAL RELATED COSTS	90	6,780	ADMINISTRATIVE & GENERAL	6	6,780
TOTAL RECLASSIFICATIONS FOR CODE F			6,780			6,780

RECLASS CODE: G
EXPLANATION : FRONT DESK AND SECURITY SALARY EXPEN

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	157,916	PHYSICAL THERAPY	50	157,916
TOTAL RECLASSIFICATIONS FOR CODE G			157,916			157,916

RECLASS CODE: H
EXPLANATION : PT NURSING SALARY EXPENSE

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	PHYSICAL THERAPY	50	46,463	ADULTS & PEDIATRICS	25	46,463
TOTAL RECLASSIFICATIONS FOR CODE H			46,463			46,463

Health Financial Systems MCRIF32 FOR RANKEN JORDAN IN LIEU OF FORM CMS-2552-96(09/1996)

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS

I PROVIDER NO: 26-3303 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET A-7 I PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS PURCHASES	ACQUISITIONS DONATION	ACQUISITIONS TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		1	2	3	4	5	6	7
1	LAND	2,359,177					2,359,177	
2	LAND IMPROVEMENTS		1,038,790		1,038,790		1,038,790	
3	BUILDINGS & FIXTURE	19,873,426	223,966		223,966		20,097,392	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	3,470,675	320,022		320,022		3,790,697	
7	SUBTOTAL	25,703,278	1,582,778		1,582,778		27,286,056	
8	RECONCILING ITEMS							
9	TOTAL	25,703,278	1,582,778		1,582,778		27,286,056	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
		GROSS ASSETS	CAPITLIZED GROSS ASSETS LEASES	FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	TOTAL
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	23,371,220		23,371,220	.856526	51,739	5,807		57,546
4	NEW CAP REL COSTS-MV	3,914,836		3,914,836	.143474	8,667	973		9,640
5	TOTAL	27,286,056		27,286,056	1.000000	60,406	6,780		67,186

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	496,534		998,427	51,739	5,807	368,231	1,920,738
4	NEW CAP REL COSTS-MV	386,188			8,667	973		395,828
5	TOTAL	882,722		998,427	60,406	6,780	368,231	2,316,566

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

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	882,722					13,921	896,643
4	NEW CAP REL COSTS-MV							
5	TOTAL	882,722					13,921	896,643

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: 26-3303 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET A-8

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST. A-7 REF. 5
1	INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5	INVESTMENT INCOME-OTHER					
6	TRADE, QUANTITY AND TIME DISCOUNTS					
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES					
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-1,522,716			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS					
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-9,203	ADMINISTRATIVE & GENERAL	6	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES					
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37	LOBBYING EXPENSE	A	-8,494	ADMINISTRATIVE & GENERAL	6	
38	ADVERTISING EXPENSE	A	-117,750	ADMINISTRATIVE & GENERAL	6	
39	MARKETING SALARY EXPENSE	A	-160,861	ADMINISTRATIVE & GENERAL	6	
40	MARKETING BENEFIT EXPENSE	A	-33,472	EMPLOYEE BENEFITS	5	
41	MARKETING OTHER EXPENSE	A	-18,110	ADMINISTRATIVE & GENERAL	6	
42	DEVELOPMENT SALARY EXPENSE	A	-115,154	ADMINISTRATIVE & GENERAL	6	
43	DEVELOPMENT BENEFIT EXPENSE	A	-28,741	EMPLOYEE BENEFITS	5	
44	DEVELOPMENT OTHER EXPENSE	A	-75,798	ADMINISTRATIVE & GENERAL	6	
45	MISCELLANEOUS REVENUE	B	-22,828	ADMINISTRATIVE & GENERAL	6	
46	LOSS ON EARLY EXTINGUISHMENT OF DEBT	A	354,310	NEW CAP REL COSTS-BLDG &	3	14
47	COUNTRY CLUB DUES	A	-7,491	ADMINISTRATIVE & GENERAL	6	
48	HEALTH LINK ADMINISTRATIVE EXPENSES	A	11,548	ADMINISTRATIVE & GENERAL	6	
49	PHYSICIAN RECRUITMENT EXPENSE	A	-5,044	ADULTS & PEDIATRICS	25	
49.01	DONATION EXPENSE	A	-15,493	ADMINISTRATIVE & GENERAL	6	
49.02	PROVIDER BASED PHYSICIAN BENEFITS	A	-178,298	EMPLOYEE BENEFITS	5	
49.03	GIFT IN KIND	A	-35,607	ADMINISTRATIVE & GENERAL	6	
50	TOTAL (SUM OF LINES 1 THRU 49)		-1,989,202			

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | PROVIDER NO: 26-3303 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET A-8-1

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

LINE NO.		COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUST-MENTS	WKSHT A-7 COL. REF.
	1	2	3	4	5	6	
1	6	ADMINISTRATIVE & GENERAL	LEGAL FEES	186,914	186,914		
2	6	ADMINISTRATIVE & GENERAL	PAINTING	3,668	3,668		
3	7	MAINTENANCE & REPAIRS	HVAC REPAIRS	24,195	24,195		
4							
5		TOTALS		214,777	214,777		

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

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

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

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
	1	2	3	4	5	6
1	E	THOMAS MINOGUE	0.00	THOMPSON COBURN	0.00	LAW FIRM
2	E	WALTER BAZANM, JR.	0.00	BAZAN PAINTING CO.	0.00	PAINTING COMPANY
3	E	GEORGE R EDINGER, SR.	0.00	C & R MECHANICAL CO.	0.00	HVAC COMPANY
4			0.00		0.00	
5			0.00		0.00	

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I 26-3303 I
I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I
I PREPARED 11/23/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFES-SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
	1	2	3	4	5	6	7	8	9
1	25	ADULTS AND PEDS/ AGGREGAT	1,559,908	1,510,326	49,582	140,600	520	35,150	1,758
2									
3									
4									
5									
6									
7									
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24									
25									
26									
27									
28									
29									
30									
101		TOTAL	1,559,908	1,510,326	49,582		520	35,150	1,758

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I 26-3303 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET A-8-2 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	25	ADULTS AND PEDS/ AGGREGAT			64,256	2,042	37,192	12,390	1,522,716
2									
3									
4									
5									
6									
7									
8									
9									
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25									
26									
27									
28									
29									
30									
101		TOTAL			64,256	2,042	37,192	12,390	1,522,716

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010
I 26-3303 I FROM 7/ 1/2009 I NOT A CMS WORKSHEET
I I TO 6/30/2010 I

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

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: 26-3303 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET B I PART I

	COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	EMPLOYEE BENEFITS	SUBTOTAL	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
		0	3	4	5	5a.00	6	7
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &	1,920,738	1,920,738					
004	NEW CAP REL COSTS-MVBLE E	395,828		395,828				
005	EMPLOYEE BENEFITS	2,742,568			2,742,568			
006	ADMINISTRATIVE & GENERAL	4,203,138	314,515	64,816	487,343	5,069,812	5,069,812	
007	MAINTENANCE & REPAIRS	888,772	315,344	64,986	99,823	1,368,925	442,858	1,811,783
011	DIETARY	273,068	51,649	10,644	55,226	390,587	126,358	72,491
014	NURSING ADMINISTRATION	916,011	125,570	25,878	245,684	1,313,143	424,812	176,241
018	SOCIAL SERVICE	216,301	49,164	10,132	34,367	309,964	100,276	69,003
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	4,123,401	905,597	186,626	978,492	6,194,116	2,003,848	1,271,030
	ANCILLARY SRVC COST CNTRS							
041	RADIOLOGY-DIAGNOSTIC	55,121				55,121	17,832	
044	LABORATORY	58,661				58,661	18,977	
049	RESPIRATORY THERAPY	1,287,908			218,786	1,506,694	487,428	
050	PHYSICAL THERAPY	1,924,276	158,899	32,746	487,147	2,603,068	842,113	223,018
055	MEDICAL SUPPLIES CHARGED	560,451			48,473	608,924	196,992	
056	DRUGS CHARGED TO PATIENTS	1,083,425			87,227	1,170,652	378,715	
	OUTPAT SERVICE COST CNTRS							
062	OBSERVATION BEDS (NON-DIS							
	OTHER REIMBURS COST CNTRS							
068	OTHER REIMBURSABLE COST C	91,506				91,506	29,603	
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	20,741,173	1,920,738	395,828	2,742,568	20,741,173	5,069,812	1,811,783
	NONREIMBURS COST CENTERS							
100	RESPITE							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	20,741,173	1,920,738	395,828	2,742,568	20,741,173	5,069,812	1,811,783

	COST CENTER DESCRIPTION	DIETARY	NURSING ADMINISTRATION	SOCIAL SERVICE	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
		11	14	18	25	26	27
	GENERAL SERVICE COST CNTR						
003	NEW CAP REL COSTS-BLDG &						
004	NEW CAP REL COSTS-MVBLE E						
005	EMPLOYEE BENEFITS						
006	ADMINISTRATIVE & GENERAL						
007	MAINTENANCE & REPAIRS						
011	DIETARY	589,436					
014	NURSING ADMINISTRATION		1,914,196				
018	SOCIAL SERVICE			479,243			
	INPAT ROUTINE SRVC CNTRS						
025	ADULTS & PEDIATRICS	589,436	1,889,291	479,243	12,426,964		12,426,964
	ANCILLARY SRVC COST CNTRS						
041	RADIOLOGY-DIAGNOSTIC				72,953		72,953
044	LABORATORY				77,638		77,638
049	RESPIRATORY THERAPY				1,994,122		1,994,122
050	PHYSICAL THERAPY		24,905		3,693,104		3,693,104
055	MEDICAL SUPPLIES CHARGED				805,916		805,916
056	DRUGS CHARGED TO PATIENTS				1,549,367		1,549,367
	OUTPAT SERVICE COST CNTRS						
062	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
068	OTHER REIMBURSABLE COST C				121,109		121,109
	SPEC PURPOSE COST CENTERS						
095	SUBTOTALS	589,436	1,914,196	479,243	20,741,173		20,741,173
	NONREIMBURS COST CENTERS						
100	RESPITE						
101	CROSS FOOT ADJUSTMENT						
102	NEGATIVE COST CENTER						
103	TOTAL	589,436	1,914,196	479,243	20,741,173		20,741,173

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: 26-3303 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET B I PART III

	COST CENTER DESCRIPTION	DIR ASSGNED NEW CAPITAL REL COSTS	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
		0	3	4	4a	5	6	7
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL	43,291	314,515	64,816	422,622		422,622	
007	MAINTENANCE & REPAIRS	3,599	315,344	64,986	383,929		36,917	420,846
011	DIETARY		51,649	10,644	62,293		10,533	16,838
014	NURSING ADMINISTRATION		125,570	25,878	151,448		35,413	40,938
018	SOCIAL SERVICE		49,164	10,132	59,296		8,359	16,028
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS		905,597	186,626	1,092,223		167,039	295,239
	ANCILLARY SRVC COST CNTRS							
041	RADIOLOGY-DIAGNOSTIC						1,487	
044	LABORATORY						1,582	
049	RESPIRATORY THERAPY	99,833			99,833		40,633	
050	PHYSICAL THERAPY	2,200	158,899	32,746	193,845		70,200	51,803
055	MEDICAL SUPPLIES CHARGED	146,758			146,758		16,421	
056	DRUGS CHARGED TO PATIENTS						31,570	
	OUTPAT SERVICE COST CNTRS							
062	OBSERVATION BEDS (NON-DIS							
	OTHER REIMBURS COST CNTRS							
068	OTHER REIMBURSABLE COST C						2,468	
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	295,681	1,920,738	395,828	2,612,247		422,622	420,846
	NONREIMBURS COST CENTERS							
100	RESPITE							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	295,681	1,920,738	395,828	2,612,247		422,622	420,846

ALLOCATION OF NEW CAPITAL RELATED COSTS | PROVIDER NO: 26-3303 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET B | PART III

	COST CENTER DESCRIPTION	DIETARY	NURSING ADMINISTRATION	SOCIAL SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		11	14	18	25	26	27
	GENERAL SERVICE COST CNTR						
003	NEW CAP REL COSTS-BLDG &						
004	NEW CAP REL COSTS-MVBLE E						
005	EMPLOYEE BENEFITS						
006	ADMINISTRATIVE & GENERAL						
007	MAINTENANCE & REPAIRS						
011	DIETARY	89,664					
014	NURSING ADMINISTRATION		227,799				
018	SOCIAL SERVICE			83,683			
	INPAT ROUTINE SRVC CNTRS						
025	ADULTS & PEDIATRICS	89,664	224,835	83,683	1,952,683		1,952,683
	ANCILLARY SRVC COST CNTRS						
041	RADIOLOGY-DIAGNOSTIC				1,487		1,487
044	LABORATORY				1,582		1,582
049	RESPIRATORY THERAPY				140,466		140,466
050	PHYSICAL THERAPY		2,964		318,812		318,812
055	MEDICAL SUPPLIES CHARGED				163,179		163,179
056	DRUGS CHARGED TO PATIENTS				31,570		31,570
	OUTPAT SERVICE COST CNTRS						
062	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
068	OTHER REIMBURSABLE COST C				2,468		2,468
	SPEC PURPOSE COST CENTERS						
095	SUBTOTALS	89,664	227,799	83,683	2,612,247		2,612,247
	NONREIMBURS COST CENTERS						
100	RESPITE						
101	CROSS FOOT ADJUSTMENTS						
102	NEGATIVE COST CENTER						
103	TOTAL	89,664	227,799	83,683	2,612,247		2,612,247

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: 26-3303 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP REL COSTS-BLDG & (SQUARE FEET)	NEW CAP REL COSTS-MVBLE E (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCIL-IATION	ADMINISTRATIV E & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)
		3	4	5	6a.00	6	7
	GENERAL SERVICE COST						
003	NEW CAP REL COSTS-BLD	60,282					
004	NEW CAP REL COSTS-MVB		60,282				
005	EMPLOYEE BENEFITS			10,143,934			
006	ADMINISTRATIVE & GENE	9,871	9,871	1,802,538	-5,069,812	15,671,361	
007	MAINTENANCE & REPAIRS	9,897	9,897	369,215		1,368,925	40,514
011	DIETARY	1,621	1,621	204,263		390,587	1,621
014	NURSING ADMINISTRATIO	3,941	3,941	908,713		1,313,143	3,941
018	SOCIAL SERVICE	1,543	1,543	127,112		309,964	1,543
	INPAT ROUTINE SRVC CN						
025	ADULTS & PEDIATRICS	28,422	28,422	3,619,143		6,194,116	28,422
	ANCILLARY SRVC COST C						
041	RADIOLOGY-DIAGNOSTIC					55,121	
044	LABORATORY					58,661	
049	RESPIRATORY THERAPY			809,225		1,506,694	
050	PHYSICAL THERAPY	4,987	4,987	1,801,813		2,603,068	4,987
055	MEDICAL SUPPLIES CHAR			179,286		608,924	
056	DRUGS CHARGED TO PATI			322,626		1,170,652	
	OUTPAT SERVICE COST C						
062	OBSERVATION BEDS (NON						
	OTHER REIMBURS COST C						
068	OTHER REIMBURSABLE CO					91,506	
	SPEC PURPOSE COST CEN						
095	SUBTOTALS	60,282	60,282	10,143,934	-5,069,812	15,671,361	40,514
	NONREIMBURS COST CENT						
100	RESPITE						
101	CROSS FOOT ADJUSTMENT						
102	NEGATIVE COST CENTER						
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	1,920,738	395,828	2,742,568		5,069,812	1,811,783
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	31.862546	6.566272	.270365		.323508	44.719924
105	COST TO BE ALLOCATED (WRKSHT B, PART II)						
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)						
107	COST TO BE ALLOCATED (WRKSHT B, PART III					422,622	420,846
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)					.026968	10.387668

	COST CENTER DESCRIPTION	DIETARY (MEALS ERVED	NURSING ADMIN S(DIRECT)SING HRS	ISTRATION SOCIAL SERVIC NR(TIME)SPENT E)
		11	14	18
	GENERAL SERVICE COST			
003	NEW CAP REL COSTS-BLD			
004	NEW CAP REL COSTS-MVB			
005	EMPLOYEE BENEFITS			
006	ADMINISTRATIVE & GENE			
007	MAINTENANCE & REPAIRS			
011	DIETARY	31,797		
014	NURSING ADMINISTRATIO		155,720	
018	SOCIAL SERVICE			6,225
	INPAT ROUTINE SRVC CN			
025	ADULTS & PEDIATRICS	31,797	153,694	6,225
	ANCILLARY SRVC COST C			
041	RADIOLOGY-DIAGNOSTIC			
044	LABORATORY			
049	RESPIRATORY THERAPY			
050	PHYSICAL THERAPY		2,026	
055	MEDICAL SUPPLIES CHAR			
056	DRUGS CHARGED TO PATI			
	OUTPAT SERVICE COST C			
062	OBSERVATION BEDS (NON			
	OTHER REIMBURS COST C			
068	OTHER REIMBURSABLE CO			
	SPEC PURPOSE COST CEN			
095	SUBTOTALS	31,797	155,720	6,225
	NONREIMBURS COST CENT			
100	RESPITE			
101	CROSS FOOT ADJUSTMENT			
102	NEGATIVE COST CENTER			
103	COST TO BE ALLOCATED (PER WRKSHT B, PART	589,436	1,914,196	479,243
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	18.537472	12.292551	76.986827
105	COST TO BE ALLOCATED (PER WRKSHT B, PART			
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)			
107	COST TO BE ALLOCATED (PER WRKSHT B, PART	89,664	227,799	83,683
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	2.819889	1.462876	13.443052

COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER NO: 26-3303 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET C | PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27	THERAPY ADJUSTMENT	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS
		1	2	3	4	5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	12,426,964		12,426,964		
	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC	72,953		72,953		
44	LABORATORY	77,638		77,638		
49	RESPIRATORY THERAPY	1,994,122		1,994,122		
50	PHYSICAL THERAPY	3,693,104		3,693,104		
55	MEDICAL SUPPLIES CHARGED	805,916		805,916		
56	DRUGS CHARGED TO PATIENTS	1,549,367		1,549,367		
	OUTPAT SERVICE COST CNTRS					
62	OBSERVATION BEDS (NON-DIS					
	OTHER REIMBURS COST CNTRS					
68	OTHER REIMBURSABLE COST C	121,109		121,109		
101	SUBTOTAL	20,741,173		20,741,173		
102	LESS OBSERVATION BEDS					
103	TOTAL	20,741,173		20,741,173		

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: 26-3303 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET C I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	19,078,200		19,078,200			
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC	79,512		79,512	.917509	.917509	
44	LABORATORY	179,832		179,832	.431725	.431725	
49	RESPIRATORY THERAPY	5,648,975		5,648,975	.353006	.353006	
50	PHYSICAL THERAPY	2,008,243	1,630,813	3,639,056	1.014852	1.014852	
55	MEDICAL SUPPLIES CHARGED	654,959		654,959	1.230483	1.230483	
56	DRUGS CHARGED TO PATIENTS	705,969		705,969	2.194667	2.194667	
	OUTPAT SERVICE COST CNTRS						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
68	OTHER REIMBURSABLE COST C	581,293		581,293	.208344	.208344	
101	SUBTOTAL	28,936,983	1,630,813	30,567,796			
102	LESS OBSERVATION BEDS						
103	TOTAL	28,936,983	1,630,813	30,567,796			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

PROVIDER NO: 26-3303
PERIOD: FROM 7/ 1/2009 TO 6/30/2010

PREPARED 11/23/2010
WORKSHEET C
PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27	THERAPY ADJUSTMENT	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS
		1	2	3	4	5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	12,426,964		12,426,964		
	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC	72,953		72,953		
44	LABORATORY	77,638		77,638		
49	RESPIRATORY THERAPY	1,994,122		1,994,122		
50	PHYSICAL THERAPY	3,693,104		3,693,104		
55	MEDICAL SUPPLIES CHARGED	805,916		805,916		
56	DRUGS CHARGED TO PATIENTS	1,549,367		1,549,367		
	OUTPAT SERVICE COST CNTRS					
62	OBSERVATION BEDS (NON-DIS					
	OTHER REIMBURS COST CNTRS					
68	OTHER REIMBURSABLE COST C	121,109		121,109		
101	SUBTOTAL	20,741,173		20,741,173		
102	LESS OBSERVATION BEDS					
103	TOTAL	20,741,173		20,741,173		

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

PROVIDER NO: 26-3303
PERIOD: FROM 7/ 1/2009 TO 6/30/2010
PREPARED 11/23/2010
WORKSHEET C
PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	19,078,200		19,078,200			
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC	79,512		79,512	.917509	.917509	
44	LABORATORY	179,832		179,832	.431725	.431725	
49	RESPIRATORY THERAPY	5,648,975		5,648,975	.353006	.353006	
50	PHYSICAL THERAPY	2,008,243	1,630,813	3,639,056	1.014852	1.014852	
55	MEDICAL SUPPLIES CHARGED	654,959		654,959	1.230483	1.230483	
56	DRUGS CHARGED TO PATIENTS	705,969		705,969	2.194667	2.194667	
	OUTPAT SERVICE COST CNTRS						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
68	OTHER REIMBURSABLE COST C	581,293		581,293	.208344	.208344	
101	SUBTOTAL	28,936,983	1,630,813	30,567,796			
102	LESS OBSERVATION BEDS						
103	TOTAL	28,936,983	1,630,813	30,567,796			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 & III, 1	CAPITAL COST WKST B PT II COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC	72,953	1,487	71,466			72,953
44	LABORATORY	77,638	1,582	76,056			77,638
49	RESPIRATORY THERAPY	1,994,122	140,466	1,853,656			1,994,122
50	PHYSICAL THERAPY	3,693,104	318,812	3,374,292			3,693,104
55	MEDICAL SUPPLIES CHARGED	805,916	163,179	642,737			805,916
56	DRUGS CHARGED TO PATIENTS	1,549,367	31,570	1,517,797			1,549,367
	OUTPAT SERVICE COST CNTRS						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
68	OTHER REIMBURSABLE COST C	121,109	2,468	118,641			121,109
101	SUBTOTAL	8,314,209	659,564	7,654,645			8,314,209
102	LESS OBSERVATION BEDS						
103	TOTAL	8,314,209	659,564	7,654,645			8,314,209

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS

PROVIDER NO: 26-3303 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET C PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC	79,512	.917509	.917509
44	LABORATORY	179,832	.431725	.431725
49	RESPIRATORY THERAPY	5,648,975	.353006	.353006
50	PHYSICAL THERAPY	3,639,056	1.014852	1.014852
55	MEDICAL SUPPLIES CHARGED	654,959	1.230483	1.230483
56	DRUGS CHARGED TO PATIENTS	705,969	2.194667	2.194667
	OUTPAT SERVICE COST CNTRS			
62	OBSERVATION BEDS (NON-DIS			
	OTHER REIMBURS COST CNTRS			
68	OTHER REIMBURSABLE COST C	581,293	.208344	.208344
101	SUBTOTAL	11,489,596		
102	LESS OBSERVATION BEDS			
103	TOTAL	11,489,596		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III,COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC	72,953	1,487	71,466			72,953
44	LABORATORY	77,638	1,582	76,056			77,638
49	RESPIRATORY THERAPY	1,994,122	140,466	1,853,656			1,994,122
50	PHYSICAL THERAPY	3,693,104	318,812	3,374,292			3,693,104
55	MEDICAL SUPPLIES CHARGED	805,916	163,179	642,737			805,916
56	DRUGS CHARGED TO PATIENTS	1,549,367	31,570	1,517,797			1,549,367
	OUTPAT SERVICE COST CNTRS						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
68	OTHER REIMBURSABLE COST C	121,109	2,468	118,641			121,109
101	SUBTOTAL	8,314,209	659,564	7,654,645			8,314,209
102	LESS OBSERVATION BEDS						
103	TOTAL	8,314,209	659,564	7,654,645			8,314,209

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS
SPECIAL TITLE XIX WORKSHEET

PROVIDER NO: 26-3303
PERIOD: FROM 7/ 1/2009 TO 6/30/2010

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC	79,512	.917509	.917509
44	LABORATORY	179,832	.431725	.431725
49	RESPIRATORY THERAPY	5,648,975	.353006	.353006
50	PHYSICAL THERAPY	3,639,056	1.014852	1.014852
55	MEDICAL SUPPLIES CHARGED	654,959	1.230483	1.230483
56	DRUGS CHARGED TO PATIENTS	705,969	2.194667	2.194667
	OUTPAT SERVICE COST CNTRS			
62	OBSERVATION BEDS (NON-DIS			
	OTHER REIMBURS COST CNTRS			
68	OTHER REIMBURSABLE COST C	581,293	.208344	.208344
101	SUBTOTAL	11,489,596		
102	LESS OBSERVATION BEDS			
103	TOTAL	11,489,596		

Health Financial Systems MCRIF32 FOR RANKEN JORDAN IN LIEU OF FORM CMS-2552-96(09/1997)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | PROVIDER NO: 26-3303 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET D | PART I

TITLE XVIII, PART A TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL CAPITAL REL COST (B, II)	OLD CAPITAL SWING BED ADJUSTMENT	OLD CAPITAL REDUCED CAP RELATED COST	NEW CAPITAL CAPITAL REL COST (B,III)	NEW CAPITAL SWING BED ADJUSTMENT	NEW CAPITAL REDUCED CAP RELATED COST
		1	2	3	4	5	6
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS				1,952,683		1,952,683
101	TOTAL				1,952,683		1,952,683

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
26-3303	FROM 7/ 1/2009	WORKSHEET D
	TO 6/30/2010	PART I

TITLE XVIII, PART A TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	INPAT PROGRAM OLD CAP CST 10	NEW CAPITAL PER DIEM 11	INPAT PROGRAM NEW CAP CST 12
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	10,599	30			184.23	5,527
101	TOTAL	10,599	30				5,527

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: 26-3303 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I COMPONENT NO: 26-3303 I PREPARED 11/23/2010 I WORKSHEET D I PART II

TITLE XVIII, PART A HOSPITAL TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	OLD CAPITAL CST/CHRG RATIO 5	OLD CAPITAL COSTS 6
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC		1,487	79,512			
44	LABORATORY		1,582	179,832	280		
49	RESPIRATORY THERAPY		140,466	5,648,975	19,297		
50	PHYSICAL THERAPY		318,812	3,639,056	1,706		
55	MEDICAL SUPPLIES CHARGED		163,179	654,959	4,788		
56	DRUGS CHARGED TO PATIENTS		31,570	705,969	545		
	OUTPAT SERVICE COST CNTRS						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
68	OTHER REIMBURSABLE COST C		2,468	581,293	326		
101	TOTAL		659,564	11,489,596	26,942		

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

TITLE XVIII, PART A HOSPITAL

WKST A LINE NO.	COST CENTER DESCRIPTION	NEW CAPITAL CST/CHRG RATIO 7	COSTS 8
	ANCILLARY SRVC COST CNTRS		
41	RADIOLOGY-DIAGNOSTIC	.018702	
44	LABORATORY	.008797	2
49	RESPIRATORY THERAPY	.024866	480
50	PHYSICAL THERAPY	.087608	149
55	MEDICAL SUPPLIES CHARGED	.249144	1,193
56	DRUGS CHARGED TO PATIENTS	.044719	24
	OUTPAT SERVICE COST CNTRS		
62	OBSERVATION BEDS (NON-DIS		
	OTHER REIMBURS COST CNTRS		
68	OTHER REIMBURSABLE COST C	.004246	1
101	TOTAL		1,849

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

I PROVIDER NO: 26-3303 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET D I PART III I TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	MED EDUCATN COST 2	SWING BED ADJ AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS					10,599	
101	TOTAL					10,599	

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

I PROVIDER NO:	I PERIOD:	I PREPARED 11/23/2010
I 26-3303	I FROM 7/ 1/2009	I WORKSHEET D
I	I TO 6/30/2010	I PART III

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
26-3303	FROM 7/ 1/2009	WORKSHEET D
COMPONENT NO:	TO 6/30/2010	PART IV
26-3303		

TITLE XVIII, PART A HOSPITAL TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	1.01	MED ED NRS SCHOOL COST 2	MED ED ALLIED HEALTH COST 2.01	MED ED ALL OTHER COSTS 2.02	BLOOD CLOT FOR HEMOPHILIACS 2.03
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
	OUTPAT SERVICE COST CNTRS						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
68	OTHER REIMBURSABLE COST C						
101	TOTAL						

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
26-3303	FROM 7/ 1/2009	WORKSHEET D
COMPONENT NO:	TO 6/30/2010	PART IV
26-3303		

TITLE XVIII, PART A HOSPITAL TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS							
41	RADIOLOGY-DIAGNOSTIC			79,512				
44	LABORATORY			179,832			280	
49	RESPIRATORY THERAPY			5,648,975			19,297	
50	PHYSICAL THERAPY			3,639,056			1,706	
55	MEDICAL SUPPLIES CHARGED			654,959			4,788	
56	DRUGS CHARGED TO PATIENTS			705,969			545	
	OUTPAT SERVICE COST CNTRS							
62	OBSERVATION BEDS (NON-DIS							
	OTHER REIMBURS COST CNTRS							
68	OTHER REIMBURSABLE COST C			581,293			326	
101	TOTAL			11,489,596			26,942	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
26-3303	FROM 7/ 1/2009	WORKSHEET D
COMPONENT NO:	TO 6/30/2010	PART IV
26-3303		

TITLE XVIII, PART A HOSPITAL TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	OUTPAT PROG CHARGES 8	OUTPAT PROG D,V COL 5.03 8.01	OUTPAT PROG D,V COL 5.04 8.02	OUTPAT PROG PASS THRU COST 9	COL 8.01 * COL 5 9.01	COL 8.02 * COL 5 9.02
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
	OUTPAT SERVICE COST CNTRS						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
68	OTHER REIMBURSABLE COST C						
101	TOTAL						

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 26-3303 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET D I PART V

I COMPONENT NO: 26-3303 I

TITLE XIX - O/P HOSPITAL

		Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic	All Other (1)
	Cost Center Description	1	2	3	4	5
(A)	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC	.917509				
44	LABORATORY	.431725				
49	RESPIRATORY THERAPY	.353006				
50	PHYSICAL THERAPY	1.014852				255,844
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.230483				
56	DRUGS CHARGED TO PATIENTS	2.194667				
	OUTPAT SERVICE COST CNTRS					
62	OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
68	OTHER REIMBURSABLE COST CENTERS	.208344				
101	SUBTOTAL					255,844
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					255,844

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 26-3303 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | COMPONENT NO: 26-3303 | PREPARED 11/23/2010 WORKSHEET D PART V

TITLE XIX - O/P HOSPITAL

(A)	Cost Center Description	PPS Services FYB to 12/31 5.01	Non-PPS Services 5.02	PPS Services 1/1 to FYE 5.03	Outpatient Ambulatory Surgical Ctr 6	Outpatient Radialogy 7
	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY					
49	RESPIRATORY THERAPY					
50	PHYSICAL THERAPY					
55	MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	DRUGS CHARGED TO PATIENTS					
	OUTPAT SERVICE COST CNTRS					
62	OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
68	OTHER REIMBURSABLE COST CENTERS					
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 26-3303 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET D | PART V

COMPONENT NO: 26-3303

TITLE XIX - O/P HOSPITAL

	Cost Center Description	Other Outpatient Diagnostic 8	All Other 9	PPS Services FYB to 12/31 9.01	Non-PPS Services 9.02	PPS Services 1/1 to FYE 9.03
(A)	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY					
49	RESPIRATORY THERAPY					
50	PHYSICAL THERAPY		259,644			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	DRUGS CHARGED TO PATIENTS					
	OUTPAT SERVICE COST CNTRS					
62	OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
68	OTHER REIMBURSABLE COST CENTERS					
101	SUBTOTAL		259,644			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES		259,644			

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

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
26-3303	FROM 7/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2010	PART I
26-3303		

TITLE XVIII PART A HOSPITAL TEFRA

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	10,599
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	10,599
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	10,599
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	30
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	12,426,964
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	12,426,964
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	19,078,200
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	19,078,200
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.651370
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,800.00
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	12,426,964

TITLE XVIII PART A HOSPITAL TEFRA

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	1,172.47
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	35,174
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	35,174

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

1

48	PROGRAM INPATIENT ANCILLARY SERVICE COST	15,820
49	TOTAL PROGRAM INPATIENT COSTS	50,994

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	5,527
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	1,849
52	TOTAL PROGRAM EXCLUDABLE COST	7,376
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	43,618

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES	2
55	TARGET AMOUNT PER DISCHARGE	29,574.19
56	TARGET AMOUNT	59,148
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	15,530
58	BONUS PAYMENT	1,183
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	52,177
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

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
26-3303	FROM 7/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2010	PART III
26-3303		

TITLE XVIII PART A HOSPITAL TEFRA

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

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	
72	PER DIEM CAPITAL-RELATED COSTS	
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,172.47
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		12,426,964			
87	NEW CAPITAL-RELATED COST	1,952,683	12,426,964	.157133		
88	NON PHYSICIAN ANESTHETIST		12,426,964			
89	MEDICAL EDUCATION		12,426,964			
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
26-3303	FROM 7/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2010	PART I
26-3303		

TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	10,599
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	10,599
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	10,599
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	4,840
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	12,426,964
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	12,426,964
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	19,078,200
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	19,078,200
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.651370
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,800.00
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	12,426,964

TITLE XIX - I/P HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	1,172.47
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	5,674,755
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	5,674,755

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

		1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	3,028,118
49	TOTAL PROGRAM INPATIENT COSTS	8,702,873
	PASS THROUGH COST ADJUSTMENTS	
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	
52	TOTAL PROGRAM EXCLUDABLE COST	
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	
	TARGET AMOUNT AND LIMIT COMPUTATION	
54	PROGRAM DISCHARGES	
55	TARGET AMOUNT PER DISCHARGE	
56	TARGET AMOUNT	
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	
58	BONUS PAYMENT	
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.	
58.04	RELIEF PAYMENT	
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT	
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)	
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1	
59.03	PROGRAM DISCHARGES AFTER JULY 1	
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)	
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)	
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	
	PROGRAM INPATIENT ROUTINE SWING BED COST	
60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO: 26-3303	PERIOD: FROM 7/ 1/2009 TO 6/30/2010	PREPARED 11/23/2010 WORKSHEET D-1 PART III
COMPONENT NO: 26-3303		

TITLE XIX - I/P HOSPITAL OTHER

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

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	
72	PER DIEM CAPITAL-RELATED COSTS	
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,172.47
85	OBSERVATION BED COST	

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
26-3303	FROM 7/ 1/2009	WORKSHEET D-4
COMPONENT NO:	TO 6/30/2010	
26-3303		

TITLE XVIII, PART A HOSPITAL TEFRA

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		54,000	
	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC	.917509		
44	LABORATORY	.431725	280	121
49	RESPIRATORY THERAPY	.353006	19,297	6,812
50	PHYSICAL THERAPY	1.014852	1,706	1,731
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.230483	4,788	5,892
56	DRUGS CHARGED TO PATIENTS	2.194667	545	1,196
	OUTPAT SERVICE COST CNTRS			
62	OBSERVATION BEDS (NON-DISTINCT PART)			
	OTHER REIMBURS COST CNTRS			
68	OTHER REIMBURSABLE COST CENTERS	.208344	326	68
101	TOTAL		26,942	15,820
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		26,942	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 26-3303 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I COMPONENT NO: 26-3303 I PREPARED 11/23/2010 I WORKSHEET D-4

TITLE XIX HOSPITAL OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		8,712,000	
	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC	.917509	38,682	35,491
44	LABORATORY	.431725	94,391	40,751
49	RESPIRATORY THERAPY	.353006	2,686,949	948,509
50	PHYSICAL THERAPY	1.014852	872,176	885,130
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.230483	320,864	394,818
56	DRUGS CHARGED TO PATIENTS	2.194667	294,461	646,244
	OUTPAT SERVICE COST CNTRS			
62	OBSERVATION BEDS (NON-DISTINCT PART)			
	OTHER REIMBURS COST CNTRS			
68	OTHER REIMBURSABLE COST CENTERS	.208344	370,423	77,175
101	TOTAL		4,677,946	3,028,118
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		4,677,946	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
26-3303	FROM 7/ 1/2009	WORKSHEET E-1
COMPONENT NO:	TO 6/30/2010	
26-3303		

TITLE XVIII HOSPITAL

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	AMOUNT 2	PART B MM/DD/YYYY 3	AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			13,469		
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER	.01				
	ADJUSTMENTS TO PROVIDER	.02				
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50				
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL	.99		NONE		NONE
4	TOTAL INTERIM PAYMENTS			13,469		
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01 SETTLEMENT TO PROGRAM .02		37,883		
7	TOTAL MEDICARE PROGRAM LIABILITY			51,352		

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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(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

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
26-3303	FROM 7/ 1/2009	WORKSHEET E-3
COMPONENT NO:	TO 6/30/2010	PART I
26-3303		

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

		HOSPITAL
1	INPATIENT HOSPITAL SERVICES (SEE INSTRUCTIONS)	52,177
1.01	HOSPITAL SPECIFIC AMOUNT (SEE INSTRUCTIONS)	
1.02	ENTER FROM THE PS&R, THE IRF PPS PAYMENT	
1.03	MEDICARE SSI RATIO (IRF PPS ONLY) (SEE INSTR.)	
1.04	INPATIENT REHABILITATION FACILITY LIP PAYMENTS (SEE INSTRUCTIONS)	
1.05	OUTLIER PAYMENTS	
1.06	TOTAL PPS PAYMENTS (SUM OF LINES 1.01, (1.02, 1.04 FOR COLUMNS 1 & 1.01), 1.05 AND 1.42)	
1.07	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUNCTIONS)	
	INPATIENT PSYCHIATRIC FACILITY (IPF)	
1.08	NET FEDERAL IPF PPS PAYMENTS (EXCLUDING OUTLIER, ECT, STOP-LOSS, AND MEDICAL EDUCATION PAYMENTS)	
1.09	NET IPF PPS OUTLIER PAYMENTS	
1.10	NET IPF PPS ECT PAYMENTS	
1.11	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR LATEST COST REPORT FILED PRIOR TO NOVEMBER 15, 2004 (SEE INSTRUCTIONS)	
1.12	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)	
1.13	CURRENT YEARS UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.14	CURRENT YEARS UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.15	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.16	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	
1.17	MEDICAL EDUCATION ADJUSTMENT FACTOR {((1 + (LINE 1.15/1.16)) RAISED TO THE POWER OF .5150 - 1}.	
1.18	MEDICAL EDUCATION ADJUSTMENT (LINE 1.08 MULTIPLIED BY LINE 1.17).	
1.19	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1.08, 1.09, 1.10 AND 1.18)	
1.20	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)	
	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)	52,177
5	PRIMARY PAYER PAYMENTS	
6	SUBTOTAL	52,177
7	DEDUCTIBLES	
8	SUBTOTAL	52,177
9	COINSURANCE	825
10	SUBTOTAL	51,352
11	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROF SERVS)	
11.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
11.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
12	SUBTOTAL	51,352
13	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
13.01	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)	
14	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
15	OTHER ADJUSTMENTS (SPECIFY)	
15.99	OUTLIER RECONCILIATION ADJUSTMENT	
16	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
26-3303	FROM 7/ 1/2009	WORKSHEET E-3
COMPONENT NO:	TO 6/30/2010	PART I
26-3303		

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

	RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
17	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	51,352
18	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
19	INTERIM PAYMENTS	13,469
19.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
20	BALANCE DUE PROVIDER/PROGRAM	37,883
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
26-3303	FROM 7/ 1/2009	WORKSHEET E-3
COMPONENT NO:	TO 6/30/2010	PART III
-		

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

TITLE XIX HOSPITAL

		OTHER TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
	COMPUTATION OF NET COST OF COVERED SERVICE		
1	INPATIENT HOSPITAL/SNF/NF SERVICES	8,702,873	
2	MEDICAL AND OTHER SERVICES	259,644	
3	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		
4	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)		
5	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		
6	SUBTOTAL	8,962,517	
7	INPATIENT PRIMARY PAYER PAYMENTS		
8	OUTPATIENT PRIMARY PAYER PAYMENTS		
9	SUBTOTAL	8,962,517	
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
10	ROUTINE SERVICE CHARGES	8,712,000	
11	ANCILLARY SERVICE CHARGES	4,933,790	
12	INTERNS AND RESIDENTS SERVICE CHARGES		
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE		
14	TEACHING PHYSICIANS		
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION		
16	TOTAL REASONABLE CHARGES	13,645,790	
	CUSTOMARY CHARGES		
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		
19	RATIO OF LINE 17 TO LINE 18		
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	13,645,790	
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	4,683,273	
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
23	COST OF COVERED SERVICES	8,962,517	
	PROSPECTIVE PAYMENT AMOUNT		
24	OTHER THAN OUTLIER PAYMENTS		
25	OUTLIER PAYMENTS		
26	PROGRAM CAPITAL PAYMENTS		
27	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS		
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		
30	SUBTOTAL	8,962,517	
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)		
32	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE XVIII ENTER AMOUNT FROM LINE 30	8,962,517	
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)		
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
34	EXCESS OF REASONABLE COST		
35	SUBTOTAL	8,962,517	
36	COINSURANCE		
37	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19		
38	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
38.01	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING BEFORE 10/01/05 (SEE INSTRUCTIONS)		
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)		
39	UTILIZATION REVIEW		
40	SUBTOTAL (SEE INSTRUCTIONS)	8,962,517	
41	INPATIENT ROUTINE SERVICE COST		
42	MEDICARE INPATIENT ROUTINE CHARGES		
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT OF PART A SERVICES		
45	RATIO OF LINE 43 TO 44		
46	TOTAL CUSTOMARY CHARGES		
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION		
50	OTHER ADJUSTMENTS (SPECIFY)		
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
52	SUBTOTAL	8,962,517	
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)		
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS		
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	8,962,517	
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
57	INTERIM PAYMENTS	6,788,602	
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
58	BALANCE DUE PROVIDER/PROGRAM	2,173,915	
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)		

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
26-3303	FROM 7/ 1/2009	WORKSHEET E-3
COMPONENT NO:	TO 6/30/2010	PART III
-		

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

TITLE XIX HOSPITAL	OTHER TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2

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

BALANCE SHEET | PROVIDER NO: 26-3303 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT ASSETS				
1	CASH ON HAND AND IN BANKS	115,442			
2	TEMPORARY INVESTMENTS	518,358			
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	2,940,698			
5	OTHER RECEIVABLES	194,134			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7	INVENTORY	82,966			
8	PREPAID EXPENSES	441,414			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	4,293,012			
	FIXED ASSETS				
12	LAND	2,359,177			
12.01					
13	LAND IMPROVEMENTS	1,038,790			
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	20,097,392			
14.01	LESS ACCUMULATED DEPRECIATION	-2,704,899			
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT	3,790,697			
18.01	LESS ACCUMULATED DEPRECIATION	-1,687,728			
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	22,893,429			
	OTHER ASSETS				
22	INVESTMENTS	5,571,383			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	15,742,406			
26	TOTAL OTHER ASSETS	21,313,789			
27	TOTAL ASSETS	48,500,230			

BALANCE SHEET | PROVIDER NO: 26-3303 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET G

	LIABILITIES AND FUND BALANCE	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE	191,552			
29	SALARIES, WAGES & FEES PAYABLE				
30	PAYROLL TAXES PAYABLE				
31	NOTES AND LOANS PAYABLE (SHORT TERM)	445,600			
32	DEFERRED INCOME				
33	ACCELERATED PAYMENTS				
34	DUE TO OTHER FUNDS				
35	OTHER CURRENT LIABILITIES	1,313,309			
36	TOTAL CURRENT LIABILITIES	1,950,461			
	LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE	20,023,062			
38	NOTES PAYABLE				
39	UNSECURED LOANS				
40.01	LOANS PRIOR TO 7/1/66				
40.02	ON OR AFTER 7/1/66				
41	OTHER LONG TERM LIABILITIES				
42	TOTAL LONG-TERM LIABILITIES	20,023,062			
43	TOTAL LIABILITIES	21,973,523			
	CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE	26,526,707			
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	26,526,707			
52	TOTAL LIABILITIES AND FUND BALANCES	48,500,230			

STATEMENT OF CHANGES IN FUND BALANCES

I PROVIDER NO:	I PERIOD:	I PREPARED 11/23/2010
I 26-3303	I FROM 7/ 1/2009	I WORKSHEET G-1
I	I TO 6/30/2010	I

		GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4
1	FUND BALANCE AT BEGINNING OF PERIOD		25,086,557		
2	NET INCOME (LOSS)		1,559,927		
3	TOTAL		26,646,484		
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	INCREASE IN TEMP RESTRICT	2,045			
5					
6					
7					
8					
9					
10	TOTAL ADDITIONS		2,045		
11	SUBTOTAL		26,648,529		
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	NET ASSETS RELEASED FROM	121,822			
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS		121,822		
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		26,526,707		

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | PROVIDER NO: 26-3303 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET G-2 | PARTS I & II

PART I - PATIENT REVENUES

		REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
		GENERAL INPATIENT ROUTINE CARE SERVICES			
1	00	HOSPITAL	19,078,200		19,078,200
4	00	SWING BED - SNF			
5	00	SWING BED - NF			
9	00	TOTAL GENERAL INPATIENT ROUTINE CARE	19,078,200		19,078,200
		INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15	00	TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16	00	TOTAL INPATIENT ROUTINE CARE SERVICE	19,078,200		19,078,200
17	00	ANCILLARY SERVICES	9,858,783		9,858,783
18	00	OUTPATIENT SERVICES		1,630,813	1,630,813
24	00	PHYSICIAN PROFESSIONAL FEES	291,868		291,868
25	00	TOTAL PATIENT REVENUES	29,228,851	1,630,813	30,859,664

PART II-OPERATING EXPENSES

26	00	OPERATING EXPENSES		22,730,375
		ADD (SPECIFY)		
27	00	PROVISION FOR BAD DEBT	7,518	
28	00	PROVISION FOR CHARITY CARE	161,981	
29	00			
30	00			
31	00			
32	00			
33	00	TOTAL ADDITIONS		169,499
		DEDUCT (SPECIFY)		
34	00	DEDUCT (SPECIFY)		
35	00			
36	00			
37	00			
38	00			
39	00	TOTAL DEDUCTIONS		
40	00	TOTAL OPERATING EXPENSES		22,899,874

STATEMENT OF REVENUES AND EXPENSES | PROVIDER NO: 26-3303 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET G-3

	DESCRIPTION	
1	TOTAL PATIENT REVENUES	30,859,664
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	8,929,814
3	NET PATIENT REVENUES	21,929,850
4	LESS: TOTAL OPERATING EXPENSES	22,899,874
5	NET INCOME FROM SERVICE TO PATIENTS	-970,024
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	1,618,363
7	INCOME FROM INVESTMENTS	596,440
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	9,203
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS,FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	GRANT INCOME	46,232
24.01	MISCELLANEOUS REVENUE	22,895
24.02	UNREALIZED INVESTMENT GAIN	236,818
25	TOTAL OTHER INCOME	2,529,951
26	TOTAL	1,559,927
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	1,559,927