

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

FORM APPROVED  
OMB NO. 0938-0050

WORKSHEET S  
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	I	15-0164	I	FROM 1/1/2008	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 12/31/2008	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 6/20/2009 TIME 12:00

PART I - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:

MONROE HOSPITAL L.L.C. 15-0164  
FOR THE COST REPORTING PERIOD BEGINNING 1/1/2008 AND ENDING 12/31/2008 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.

*Matthew S. Sheward*  
OFFICER OR ADMINISTRATOR OF PROVIDER(S)  
*Chief Financial Officer*  
TITLE  
DATE 6/20/09

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ECR ENCRYPTION INFORMATION  
DATE: 6/20/2009 TIME 12:00  
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ViaE1l0tVYxAPkwxksqt88byZ0w730  
QSe5Z0Q:5dEq:gxX3:LjErNlFEqsUq  
7s5V07Bzu106jGcg  
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PI ENCRYPTION INFORMATION  
DATE: 6/20/2009 TIME 12:00  
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AABD1IbAqp:MkJ4Y6LP1DmqXlTDtk0  
DipDZ0yKz:3aQe1BnRm22H0uh6f21D  
2New4:MowFOYrGm3  
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PART II - SETTLEMENT SUMMARY

	TITLE V		TITLE XVIII		TITLE XIX
	1	A 2	B 3		4
1 HOSPITAL	0	-329,199		0	1,289,182
100 TOTAL	0	-329,199		0	1,289,182

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

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

MD

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS  
 1 STREET: 4011 S. MONROE MEDICAL PARK BLVD. P.O. BOX:  
 01 CITY: BLOOMINGTON STATE: IN ZIP CODE: 47403- COUNTY: MONROE

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;					DATE	PAYMENT SYSTEM (P,T,O OR N)		
COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	CERTIFIED	V	XVIII	XIX	
0	1	2	2.01	3	4	5	6	
02.00	HOSPITAL MONROE HOSPITAL L.L.C.	15-0164		10/16/2006	N	P	P	

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2008 TO: 12/31/2008

18 TYPE OF CONTROL 1 2  
6

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1  
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? N
- 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
- 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 1 N Y 14020
- 21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 1
- 21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 1
- 21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER "Y" FOR YES, AND "N" FOR NO. N
- 22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N
- 23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N
- 23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /
- 23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /
- 23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /
- 23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION 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 IN COL. 3. / / / /
- 23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /
- 24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy) / /
- 24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). / /
- 25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R? N
- 25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4? N
- 25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II. N
- 25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. N
- 25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N
- 25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 6/20/2009  
 I 15-0164 I FROM 1/ 1/2008 I WORKSHEET S-2  
 I I TO 12/31/2008 I

25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR TIME 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)  
 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01.  
 SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.

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

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

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

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

	1	2	3	4
		0	0.0000	0.0000
28.02		0.00	0	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MISCELLANEOUS COST REPORT INFORMATION

32 IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2. N

33 IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2 Y N

34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA? Y

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

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

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

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

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

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

	V	XVIII	XIX
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	1	2 3
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE	N	N N

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  
 1 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?

TITLE XIX INPATIENT SERVICES

38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y  
 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? Y  
 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? N  
 38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? N  
 38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? N  
 40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10?  
 IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COL 2 THE HOME OFFICE PROVIDER NUMBER.  
 IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION ENTER THE NAME AND ADDRESS OF THE HOME OFFICE N  
 40.01 NAME: FI/CONTRACTOR NAME FI/CONTRACTOR #  
 40.02 STREET: P.O. BOX:  
 40.03 CITY: STATE: ZIP CODE: -  
 41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y  
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y  
 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? N 00/00/0000  
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.  
 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  
 53.01 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  
 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: 164,249  
 PAID LOSSES: 0  
 AND/OR SELF INSURANCE: 0  
 54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N  
 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N  
 56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 0. DATE Y OR N LIMIT Y OR N FEES  
 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). 0  
 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N  
 60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX  
IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 6/20/2009  
I 15-0164 I FROM 1/ 1/2008 I WORKSHEET S-2  
I I TO 12/31/2008 I

60 01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORT FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? 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 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 INSTRUCTIONS) 0

MULTICAMPUS

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

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

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00
62.01					0.00
62.02					0.00
62.03					0.00
62.04					0.00
62.05					0.00
62.06					0.00
62.07					0.00
62.08					0.00
62.09					0.00

SETTLEMENT DATA

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

HOSPITAL AND HOSPITAL HEALTH CARE  
COMPLEX STATISTICAL DATA

PROVIDER NO: 15-0164  
I PERIOD: 1/ 1/2008  
I FROM 1/ 1/2008  
I TO 12/31/2008  
I PREPARED 6/20/2009  
I WORKSHEET S-3  
I PART I

COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH N/A	TITLE V	I/P DAYS / TITLE XVIII	O/P VISITS / NOT LTCH N/A	TRIPS TOTAL TITLE XIX
1 ADULTS & PEDIATRICS	24	8,784	2.01	3	4	1,630	140
2 HMO						256	33
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	24	8,784				1,630	140
6 INTENSIVE CARE UNIT	8	2,928				620	14
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL	32	11,712				2,250	154
13 RPCH VISITS							
14 SUBPROVIDER							
15 SKILLED NURSING FACILITY							
16 NURSING FACILITY							
16 01 ICF/MR							
17 OTHER LONG TERM CARE							
18 HOME HEALTH AGENCY							
20 AMBULATORY SURGICAL CENTER (							
21 HOSPICE							
23 CORF							
25 TOTAL	32						
26 OBSERVATION BED DAYS							13
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I/P DAYS / TITLE XIX OBSERVATION BEDS ADMITTED NOT ADMITTED		O/P VISITS / TOTAL ALL PATS	TRIPS / TOTAL OBSERVATION BEDS ADMITTED NOT ADMITTED		INTERNS & RES. FTES -- LESS I&R REPL NON-PHYS ANES	
1 ADULTS & PEDIATRICS	5.01	5.02	6	6.01	6.02	7	8
2 HMO			3,331				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS			3,331				
6 INTENSIVE CARE UNIT			659				
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL			3,990				
13 RPCH VISITS							
14 SUBPROVIDER							
15 SKILLED NURSING FACILITY							
16 NURSING FACILITY							
16 01 ICF/MR							
17 OTHER LONG TERM CARE							
18 HOME HEALTH AGENCY							
20 AMBULATORY SURGICAL CENTER (							
21 HOSPICE							
23 CORF							
25 TOTAL							
26 OBSERVATION BED DAYS	1	12	319	22	297		
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I & R FTES NET	FULL TIME EMPLOYEES ON PAYROLL	EQUIV NONPAID WORKERS	TITLE V	DISCHARGES TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2 HMO					674	52	1,256
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
6 INTENSIVE CARE UNIT							
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL		201.40			674	52	1,256
13 RPCH VISITS							
14 SUBPROVIDER							
15 SKILLED NURSING FACILITY							
16 NURSING FACILITY							

HOSPITAL AND HOSPITAL HEALTH CARE  
 COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 6/20/2009  
 I 15-0164 I FROM 1/ 1/2008 I WORKSHEET S-3  
 I TO 12/31/2008 I PART I

COMPONENT	I & R FTES NET	--- FULL TIME EQUIV ---		DISCHARGES			TOTAL ALL PATIENTS
		EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	
16 01 ICF/MR	9	10	11	12	13	14	15
17 OTHER LONG TERM CARE							
18 HOME HEALTH AGENCY							
20 AMBULATORY SURGICAL CENTER (							
21 HOSPICE							
23 CORF							
25 TOTAL		201.40					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

HOSPITAL WAGE INDEX INFORMATION

I PROVIDER NO: I PERIOD: I PREPARED 6/20/2009  
 I 15-0164 I FROM 1/ 1/2008 I WORKSHEET S-3  
 I I TO 12/31/2008 I PARTS II & III

II - WAGE DATA	AMOUNT REPORTED 1	RECLASS OF SALARIES 2	ADJUSTED SALARIES 3	PAID HOURS RELATED TO SALARY 4	AVERAGE HOURLY WAGE 5	DATA SOURCE 6
SALARIES						
1 TOTAL SALARY	10,104,664		10,104,664	418,973.00	24.12	
2 NON-PHYSICIAN ANESTHETIST PART A						
3 NON-PHYSICIAN ANESTHETIST PART B						
4 PHYSICIAN - PART A						
4.01 TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
5 PHYSICIAN - PART B						
5.01 NON-PHYSICIAN - PART B						
6 INTERNS & RESIDENTS (APPRVD)						
6.01 CONTRACT SERVICES, I&R						
7 HOME OFFICE PERSONNEL						
8 SNF						
8.01 EXCLUDED AREA SALARIES	1,925,478		1,925,478	58,291.00	33.03	
OTHER WAGES & RELATED COSTS						
9 CONTRACT LABOR:						
9.01 PHARMACY SERVICES UNDER CONTRACT						
9.02 LABORATORY SERVICES UNDER CONTRACT						
9.03 MANAGEMENT & ADMINISTRATIVE UNDER CONTRACT						
10 CONTRACT LABOR: PHYS PART A						
10.01 TEACHING PHYSICIAN UNDER CONTRACT (SEE INSTRUCTIONS)						
11 HOME OFFICE SALARIES & WAGE RELATED COSTS						
12 HOME OFFICE: PHYS PART A						
12.01 TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
WAGE RELATED COSTS						
13 WAGE-RELATED COSTS (CORE)	2,112,864		2,112,864			CMS 339
14 WAGE-RELATED COSTS (OTHER)						CMS 339
15 EXCLUDED AREAS	97,040		97,040			CMS 339
16 NON-PHYS ANESTHETIST PART A						CMS 339
17 NON-PHYS ANESTHETIST PART B						CMS 339
18 PHYSICIAN PART A						CMS 339
18.01 PART A TEACHING PHYSICIANS						CMS 339
19 PHYSICIAN PART B						CMS 339
19.01 WAGE-RELATED COSTS (RHC/FQHC)						CMS 339
20 INTERNS & RESIDENTS (APPRVD)						CMS 339
OVERHEAD COSTS - DIRECT SALARIES						
21 EMPLOYEE BENEFITS	113,720		113,720	3,021.00	37.64	
22 ADMINISTRATIVE & GENERAL	1,155,665		1,155,665	59,472.00	19.43	
22.01 A & G UNDER CONTRACT						
23 MAINTENANCE & REPAIRS						
24 OPERATION OF PLANT	215,592		215,592	10,929.00	19.73	
25 LAUNDRY & LINEN SERVICE						
26 HOUSEKEEPING	240,599		240,599	18,870.00	12.75	
26.01 HOUSEKEEPING UNDER CONTRACT						
27 DIETARY	236,931		236,931	21,886.00	10.83	
27.01 DIETARY UNDER CONTRACT						
28 CAFETERIA						
29 MAINTENANCE OF PERSONNEL						
30 NURSING ADMINISTRATION	3,577		3,577	200.00	17.89	
31 CENTRAL SERVICE AND SUPPLY	128,821		128,821	6,142.00	20.97	
32 PHARMACY	342,199		342,199	9,144.00	37.42	
33 MEDICAL RECORDS & MEDICAL RECORDS LIBRARY	222,825		222,825	16,048.00	13.88	
34 SOCIAL SERVICE						
35 OTHER GENERAL SERVICE						

PART III - HOSPITAL WAGE INDEX SUMMARY

1 NET SALARIES	10,104,664		10,104,664	418,973.00	24.12	
2 EXCLUDED AREA SALARIES	1,925,478		1,925,478	58,291.00	33.03	
3 SUBTOTAL SALARIES	8,179,186		8,179,186	360,682.00	22.68	
4 SUBTOTAL OTHER WAGES & RELATED COSTS						
5 SUBTOTAL WAGE-RELATED COSTS	2,112,864		2,112,864		25.83	
6 TOTAL	10,292,050		10,292,050	360,682.00	28.53	
7 NET SALARIES						
8 EXCLUDED AREA SALARIES						
9 SUBTOTAL SALARIES						
10 SUBTOTAL OTHER WAGES & RELATED COSTS						
11 SUBTOTAL WAGE-RELATED COSTS						
12 TOTAL						
13 TOTAL OVERHEAD COSTS	2,659,929		2,659,929	145,712.00	18.25	

HOSPITAL UNCOMPENSATED CARE DATA

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 6/20/2009
I	15-0164	I	FROM 1/ 1/2008	I	WORKSHEET S-10
I		I	TO 12/31/2008	I	
I		I		I	

DESCRIPTION

UNCOMPENSATED CARE INFORMATION

- 1 DO YOU HAVE A WRITTEN CHARITY CARE POLICY?
- 2 ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER  
LINES 2.01 THRU 2.04
- 2.01 IS IT AT THE TIME OF ADMISSION?
- 2.02 IS IT AT THE TIME OF FIRST BILLING?
- 2.03 IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?
- 2.04
- 3 ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?
- 4 ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE  
JUDGMENT WITHOUT FINANCIAL DATA?
- 5 ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?
- 6 ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS)  
DATA?
- 7 ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET  
WORTH DATA?
- 8 DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD  
DEBT AND CHARITY CARE? IF YES ANSWER 8.01
- 8.01 DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT  
SERVICES?
- 9 IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN  
YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04
- 9.01 IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE  
ELIGIBILITY?
- 9.02 IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE  
CHARITY FROM BAD DEBT?
- 9.03 IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON  
CHARITY DETERMINATION?
- 9.04 IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE  
DISTINCTION IMPORTANT?
- 10 IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA,  
WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS  
(SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO  
BE A CHARITY WRITE OFF?
- 11 IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA,  
IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY  
LEVEL? IF YES ANSWER 11.01 THRU 11.04
- 11.01 IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL  
POVERTY LEVEL?
- 11.02 IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150%  
OF THE FEDERAL POVERTY LEVEL?
- 11.03 IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200%  
OF THE FEDERAL POVERTY LEVEL?
- 11.04 IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF  
THE FEDERAL POVERTY LEVEL?
- 12 ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME  
PATIENTS ON A GRADUAL SCALE?
- 13 IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH  
PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY  
MEDICAL EXPENSES?
- 14 IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED?  
IF YES ANSWER LINES 14.01 AND 14.02
- 14.01 DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT  
GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING  
COMPENSATED CARE?
- 14.02 WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM  
GOVERNMENT FUNDING?
- 15 DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE  
TO CHARITY PATIENTS?
- 16 ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE  
CHARITY CARE?
  
- UNCOMPENSATED CARE REVENUES
- 17 REVENUE FROM UNCOMPENSATED CARE
- 17.01 GROSS MEDICAID REVENUES
- 18 REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS
- 19 REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)
- 20 RESTRICTED GRANTS
- 21 NON-RESTRICTED GRANTS
- 22 TOTAL GROSS UNCOMPENSATED CARE REVENUES
  
- UNCOMPENSATED CARE COST
- 23 TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL  
INDIGENT CARE PROGRAMS
- 24 COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103,  
DIVIDED BY COLUMN 8, LINE 103) .453797
- 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 4,501,975

HOSPITAL UNCOMPENSATED CARE DATA

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	6/20/2009
I	15-0164	I	FROM 1/ 1/2008	I	WORKSHEET	S-10
I		I	TO 12/31/2008	I		
I		I		I		

DESCRIPTION

29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	2,042,983
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29)	2,042,983